Xyrem, Sodium oxybate, Lumryz

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What is the requested product?
   ❑ Xyrem ❑ Sodium oxybate
   ❑ Lumryz ❑ Other _____
2. What is the diagnosis?
   ❑ Cataplexy with narcolepsy
   ❑ Excessive daytime sleepiness with narcolepsy
   ❑ Other _____
3. What is the ICD-10 code? _____
4. Is the patient currently receiving treatment with the requested medication? ❑ Yes ❑ No *If No, skip to #7*
5. *If the diagnosis is cataplexy with narcolepsy*, has the patient demonstrated a beneficial response to treatment as defined by a decrease in cataplexy episodes from baseline? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** *If Yes or No, no further questions.* ❑ Yes ❑ No ❑ N/A, diagnosis is not listed above
6. *If the diagnosis is excessive daytime sleepiness with narcolepsy*, has the patient demonstrated a beneficial response to treatment as defined by a decrease in daytime sleepiness with narcolepsy from baseline?
   ACTION REQUIRED: If Yes, attach supporting chart note(s).
   ❑ Yes ❑ No ❑ N/A, diagnosis is not listed above *No further questions.*
7. Is the requested drug prescribed by, or in consultation with a sleep specialist? ❑ Yes ❑ No
8. Has diagnosis of narcolepsy been confirmed by a sleep lab evaluation? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Cataplexy with Narcolepsy

9. What is the member's baseline history of cataplexy attacks in a typical 2-week period?
   Indicate number of attacks: _____ attacks

Section B: Excessive Daytime Sleepiness with Narcolepsy

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization. Fax: 1-866-249-6155

10. *If the patient is greater than or equal to 18 years old*, has the patient experienced an inadequate response or intolerance to armodafinil or modafinil? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) and no further questions.*** ❑ Yes ❑ No ❑ N/A, patient is 17 years old or less, *skip to #12*

11. Does the patient have a contraindication to armodafinil and modafinil? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) and no further questions.*** ❑ Yes ❑ No *No further questions.*

12. Has the patient experienced an inadequate response, intolerance, or contraindication to at least one central nervous system (CNS) stimulant (i.e. amphetamine, dextroamphetamine, methylphenidate)?
ACTION REQUIRED: If Yes, attach supporting chart note(s). ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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