OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Xyrem® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength: Dosage Form:
❑ Check if requesting **brand**	Directions for Use:
❑ Check if request is for **continuation of therapy**	

Clinical Information (required)

Select the diagnosis below:

❑ Narcolepsy with cataplexy (narcolepsy type 1)
❑ Narcolepsy without cataplexy (narcolepsy type 2)
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Does the patient have a diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible)? ❑ **Yes** ❑ **No**

Does the patient have symptoms of cataplexy? ❑ **Yes** ❑ **No**

Does the patient have symptoms of excessive daytime sleepiness (e.g., irrepressible need to sleep or daytime lapses into sleep)? ❑ **Yes** ❑ **No**

For excessive daytime sleepiness in narcolepsy, also answer the following:

Select if the patient has had a trial and failure, contraindication, or intolerance to the following:
❑ Amphetamine-based stimulant (e.g., amphetamine, dextroamphetamine)
❑ Methylphenidate-based stimulant

Reauthorization:

If this is a reauthorization request, answer the following question:

Is there documentation demonstrating a reduction in patient's symptoms of excessive daytime sleepiness associated with Xyrem therapy? ❑ **Yes** ❑ **No**

For narcolepsy with cataplexy (narcolepsy type 1), also answer the following:

Is there documentation demonstrating a reduction in the frequency of patient's cataplexy attacks associated with Xyrem therapy? ❑ **Yes** ❑ **No**

Quantity Limit Requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: _____

Xyrem® Prior Authorization Request Form (Page 2 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.