NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for

Antinarcolepsy: Xyrem and Xywaz

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): Initial Authorization: ☐ up to 30 Days ☐ 60 Days ☐ 90 Days

Reauthorization: ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days

Clinical Information

1. Is the beneficiary 7 years of age or older? ☐ **Yes** ☐ **No**
2. Does the beneficiary have any current use of alcohol or sedative hypnotics? ☐ **Yes** ☐ **No**
3. Does the beneficiary have succinic semialdehyde dehydrogenase deficiency ☐ **Yes** ☐ **No**
4. Has the beneficiary been evaluated for history of drug abuse? ☐ **Yes** ☐ **No**
5. Will the prescriber monitor the beneficiary for signs of misuse or abuse of sodium oxybate (a.k.a. gamma-hydroxybutyrate [GHB]) including, but not limited to, the following: Use of increasingly large doses, increased frequency of use, drug seeking behavior, feigned cataplexy, etc.? ☐ **Yes** ☐ **No**
6. Does the beneficiary have a diagnosis of cataplexy associated with narcolepsy? ☐ **Yes** ☐ **No**
7. Does the beneficiary have a diagnosis of excessive daytime sleepiness due to narcolepsy with dayly periods of irrepressible need to sleep or daytime lapses into sleep occurring for ≥ 3 months? ☐ **Yes** ☐ **No**
8. Does the beneficiary have hypersomnolence secondary to another sleep disorder, neurologic disorder, medical condition, or by medicine or substance use has been ruled out? ☐ **Yes** ☐ **No**

For continuation of therapy, please answer questions 1-10

9. For a diagnosis of excessive daytime sleepiness, has the beneficiary responded to therapy with a reduction in excessive daytime sleepiness from pre-treatment baseline measured by a validated scale (e.g., Epworth Sleepiness Scale, Stanford Sleepiness Scale, Karolinska Sleepiness Scale, Cleveland Adolescent Sleepiness Questionnaire, or a Visual Analog Scale)? ☐ **Yes** ☐ **No**
10. For a diagnosis of cataplexy, has the beneficiary had a reduced frequency of cataplexy attacks from pretreatment baseline? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to CSRA at (855) 710-1969
DHB Pharmacy 93

Pharmacy PA Call Center: (866) 246-8505
03/17/2021