

Prescriber Criteria Form

Xyrem 2026 PA Fax 1481-A v2 010126.docx
Xyrem (sodium oxybate)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Xyrem (sodium oxybate).

Drug Name:
Xyrem (sodium oxybate)

Patient Name:

Patient ID:

Patient DOB:

Patient Phone:

Prescriber Name:

Prescriber Address:

City:

State:

Zip:

Prescriber Phone:

Prescriber Fax:

Diagnosis:

ICD Code(s):

Please circle the appropriate answer for each question.

1	Is the requested drug being prescribed for the treatment of cataplexy in a patient 7 years of age or older with narcolepsy? [If no, then skip to question 4.]	Yes	No
2	Is this a request for continuation of therapy? [If no, then skip to question 10.]	Yes	No
3	Has the patient experienced a decrease in cataplexy episodes with narcolepsy? [If yes, then skip to question 11.] [If no, then no further questions.]	Yes	No
4	Is the requested drug being prescribed for the treatment of excessive daytime sleepiness in a patient 7 years of age or older with narcolepsy? [If no, then no further questions.]	Yes	No
5	Is this a request for continuation of therapy? [If no, then skip to question 7.]	Yes	No
6	Has the patient experienced a decrease in daytime sleepiness with narcolepsy? [If yes, then skip to question 11.] [If no, then no further questions.]	Yes	No
7	Is the patient 18 years of age or older?	Yes	No

	[If no, then skip to question 10.]		
8	Has the patient experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) wakefulness promoting drug (e.g., armodafinil, modafinil)? [If yes, then skip to question 10.]	Yes	No
9	Does the patient have a contraindication that would prohibit a trial of central nervous system (CNS) wakefulness promoting drugs (e.g., armodafinil, modafinil)? [If no, then no further questions.]	Yes	No
10	Has the diagnosis been confirmed by sleep lab evaluation? [If no, then no further questions.]	Yes	No
11	Is the requested drug being prescribed by or in consultation with a sleep disorder specialist or neurologist?	Yes	No

Comments:	
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By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:** _____