CHORUS COMMUNITY HEALTH PLANS

Prior Authorization Form: **Xyrem**

If this is an urgent request, please call Chorus Community Health Plans Pharmacy Services.
Otherwise, please return completed form – Phone: 844-201-4677 or Fax: 844-201-4675

Please type or print neatly. Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc.

Office Contact:	Provider Specialty:	
Provider First Name:	Provider Last Name:	
Provider Phone #:	Provider Fax #:	Provider NPI #:

Patient Name:	CCHP Member ID #:	Patient DOB:	Patient Age:

Drug Requested:	Strength:	Frequency:	Quantity Dispensed (including units):
Xyrem ☐ **Brand** ☐ **Generic**	__25mg __50mg __75mg __100mg __150mg __200mg __225mg		

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

☐ **New medication** ☐ **Ongoing medication**	If ongoing, please provide start date:	If ongoing, did the member show improvement while on therapy?	☐ **Yes** ☐ **No**

Diagnosis:	**Date of diagnosis:**

Please indicate place of administration:
☐ **Physician's Office** ☐ **Hospital/Facility** ☐ **Patient Home** ☐ **Other**

Please provide hospital/facility information:

Name: _____

Phone #: _____

Address: _____

_____

Will the drug be: (select one)

☐ **Billed directly by the provider via JCODE**
JCODE: _____
☐ **Billed by a pharmacy and delivered to the provider**
☐ **Billed by a pharmacy and delivered to the patient**

Medical History

Does the member have cataplexy associated with narcolepsy? ☐ Yes ☐ No
If yes, please provide cataplexy episodes per month: Baseline: _____ Current: _____

Does the member have excessive daytime sleepiness associated with narcolepsy? ☐ Yes ☐ No
If yes, provide Epworth Sleepiness Scale score: Baseline: _____ Current: _____

Sleep study and chart documentation confirming diagnosis. ☐ Documentation enclosed ☐ Documentation not available

Is the member currently being treated with sedative hypnotic agents? ☐ Yes ☐ No

Does the member have succinic semialdehyde dehydrogenase deficiency? ☐ Yes ☐ No

Has the Prescription Drug Monitoring Program (PDMP) been reviewed? ☐ Yes ☐ No

Have the risks and adverse effects been acknowledged by the provider for the use of Xyrem in combination with alcohol and/or other CNS depressants? ☐ Yes ☐ No

Is the member currently taking a CNS Depressant? ☐ Yes ☐ No

If yes, provide plan to manage concurrent use with Xyrem ☐ Documentation enclosed ☐ Documentation not available

History of medications used to treat the above condition

Medication Trials/Previous Therapies	Dates of Therapy (Start and End Date)	Strength	Frequency	List of adverse reactions/side effects/reason for discontinuing

Please provide any additional clinical information which should be considered in the space below: