

NC Pharmacy Prior Approval Request for Antinarcology: Xyrem

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 #: _____ Provider Fax #: _____
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 daily 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.