

Request for Prior Authorization OXYBATE PRODUCTS

FAX Completed Form To 1 (800) 574-2515 Provider Help Desk 1 (877) 776-1567

	(PLEASE PRINT – ACCURACY	/ IS IMPOR	ΓANT)		. (0	,				
IA Medicaid Member ID #	Patient name	D	DOB							
Patient address										
Provider NPI	Prescriber name		Pł	Phone						
Prescriber address					Fax					
Pharmacy name	Address			Pł	Phone					
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.										
Pharmacy NPI	Pharmacy fax	Pharmacy fax NDC								
Prior authorization (PA) is required										
 for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered under the following conditions: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. A diagnosis of cataplexy associated with narcolepsy a. Confirmed by a sleep study (including PSG, MSLT, and ESS) and verified by a sleep specialist (attach results); and b. Previous trial and therapy failure with dextroamphetamine; or 3. A diagnosis of excessive daytime sleepiness associated with narcolepsy a. Confirmed by a sleep study (including PSG, MSLT, and ESS) and verified by a sleep specialist (attach results); and b. Previous trial and therapy failure at a therapeutic dose with modafinil; or 4. A diagnosis of idiopathic hypersomnia a. Confirmed by a sleep study (including PSG, MSLT, and ESS) and verified by a sleep specialist (attach results); and b. Previous trial and therapy failure at a therapeutic dose with modafinil; and 5. Will not be used in combination with other oxybate products or with pitolisant and/or solriamfetol; and 6. Patient has been counseled regarding the potential for abuse and dependence and will be closely monitored for signs of abuse and dependence; and 7. The prescriber must review the patient's use of controlled substances on the lowa Prescription Monitoring Program website prior to requesting prior authorization. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. 										
Non-Preferred										
☐ Sodium Oxybate ☐ 2	Xyrem									
	Instructions	Quantity		_	-					
Cataplexy associated with Nare specialist) Trial of dextroamphetamine:							by a s	leep		

Trial Dates: _____ Failure Reason: ____

Drug Name & Dose:



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	Excessive Daytime Sleepiness associated with Narcolepsy (Please provide results from ESS, MSLT, and PSG verified by a sleep specialist)
Tria	al of modafinil: Dose:
Tria	Il Dates:
Fail	ure Reason:
	Idiopathic Hypersomnia (Please provide results from ESS, MSLT, and PSG verified by a sleep specialist)
Tria	al of modafinil: Dose: Trial Dates:
Fai	ilure Reason:
	I medication be used in combination with other oxybate products or with pitolisant and/or solriamfetol? Yes No ient has been counseled and will be closely monitored for signs of abuse: Yes No
	scriber review of patient's controlled substances use on the Iowa PMP website: Yes Date Reviewed:
Ме	dical or contraindication reason to override trial requirements:
Atta	ach lab results and other documentation as necessary.
Pr	escriber signature (Must match prescriber listed above.) Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization, the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary, by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.

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