Prescriber Criteria Form Xyrem 2025 PA Fax 1481-A v2 010125.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 12.]	Yes ◯	No ◯
3	Has the patient experienced a decrease in cataplexy episodes with narcolepsy? [If yes, then skip to question 13.] [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 13.] [If no, then no further questions.]	Yes ◯	No ◯

7	Is the patient 18 years of age or older? [If no, then skip to question 10.]	Yes ◯	No ◯
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 12.]	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 yes, then skip to question 12.] [If no, then no further questions.]	Yes ◯	No ◯
10	Has the patient experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) stimulant drug (e.g., amphetamine, dextroamphetamine, methylphenidate)? [If yes, then skip to question 12.]	Yes ◯	No ◯
11	Does the patient have a contraindication that would prohibit a trial of central nervous system (CNS) stimulant drugs (e.g., amphetamine, dextroamphetamine, methylphenidate)? [If no, then no further questions.]	Yes ◯	No ◯
12	Has the diagnosis been confirmed by sleep lab evaluation? [If no, then no further questions.]	Yes ◯	No ◯
13	Is the requested drug being prescribed by or in consultation with a sleep disorder specialist or neurologist?	Yes ◯	No ◯

Comments:	_____

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:**_____