AmeriHealth Caritas Iowa

# AmeriHealth Caritas Iowa
# Request for Prior Authorization

## Sodium Oxybate (Xyrem®)

Form applies to IA Health Link and ***hawk-i*** plans.

**Please print – accuracy is important.**

**Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.**

| | | |
|---|---|---|
| AmeriHealth Caritas Iowa member ID #: | Patient name: | |
| Patient address: | | DOB: |
| Provider NPI: | Prescriber name: | Phone: |
| Prescriber address: | | Fax: |
| Pharmacy name: | | |
| Address: | | Phone: |
| **Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.** | | |
| Pharmacy NPI: | Pharmacy fax: | NDC: |

Prior authorization is required for sodium oxybate (Xyrem®). Payment will be considered for patients 18 years of age or older under the following conditions: 1) A diagnosis of cataplexy associated with narcolepsy verified by a recent sleep study (including a PSG, MSLT, and ESS) and previous trial and therapy failure at a therapeutic dose with one of the following tricyclic antidepressants: clomipramine, imipramine, or protriptyline. 2) Patient is enrolled in the Xyrem® REMS Program. 3) A diagnosis of excessive daytime sleepiness associated with narcolepsy verified by a recent sleep study (including a PSG, MSLT, and ESS) and previous trials and therapy failures at a therapeutic dose with a preferred amphetamine and non-amphetamine stimulant. 4) Patient has been instructed to not drink alcohol when using Xyrem®. 5) Patients with and without history of substance abuse have been counseled regarding potential for abuse and dependence and will be closely monitored for signs of abuse and dependence. 6) Requests for patients with concurrent use of a sedative hypnotic or a semialdehyde dehydrogenase deficiency will not be considered. 7) The presciber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program website at https://pmp.iowa.gov/IAPMPWebCenter/ prior to requesting prior authorizations. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

Non-Preferred: ☐ Xyrem®

Strength: Dosage Instructions: Quantity: Days Supply:

☐ Cataplexy associated with Narcolepsy (Please provide results from a recent ESS, MSLT, and PSG)

**Trial of preferred tricyclic antidepressant drug:**

Drug Name and Dose: Trial Dates: Failure Reason:

☐ Excessive Daytime Sleepiness associated with Narcolepsy (Please provide results from a recent ESS, MSLT, and PSG)

**Trial of preferred amphetamine stimulant:**

Drug Name and Dose: Trial Dates: Failure Reason:

**Trial of preferred non-amphetamine stimulant:**

Drug Name and Dose: Trial Dates: Failure Reason:

Medical or contraindication reason to override trial requirements:

Patient is enrolled in the Xyrem® REMS Program: ☐ Yes ☐ No
Patient has a history of substance abuse: ☐ Yes ☐ No
Patient has been counseled and will be closely monitored for signs of abuse: ☐ Yes ☐ No
Patient has a semialdehyde dehydrogenase deficiency: ☐ Yes ☐ No
Patient has been instructed to not drink alcohol when using Xyrem®: ☐ Yes ☐ No
Prescriber review of patient's controlled substances use on the Iowa PMP website: ☐ Yes ☐ No Date Reviewed:_____

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**Attach lab results and other documentation as necessary.**

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|---|---|
| By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment. | |
| Prescriber signature:<br>(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 Human Services, that the member continues to be eligible for Medicaid.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.