TRICARE Prior Authorization Request Form for sodium oxybate **(Lumryz, Xyrem),** calcium, magnesium, potassium & sodium oxybate salts **(Xywav)**

JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100, Hanover, MD 21076

Fax Completed Form and Applicable Progress Notes to:
(410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization will expire in one year.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:	______________	Physician Name:	______________
Address:	______________	Address:	______________
	______________		______________
Sponsor ID #	______________	Phone #:	______________
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1.	**Have other causes of sleepiness been ruled out or treated (including, but not limited to, obstructive sleep apnea, insufficient sleep syndrome, the effects of substance or medications, or other sleep disorders)?**	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2.	**For which indication is the requested medication being prescribed?**	☐ Excessive daytime sleepiness or cataplexy in a patient with narcolepsy - Proceed to question **3** ☐ Idiopathic hypersomnia - Proceed to question **5** ☐ Other – **STOP Coverage not approved**	
3.	**Was the diagnosis of narcolepsy confirmed by polysomnogram (PSG) or mean sleep latency time (MSLT) objective testing?**	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4.	**How old is the patient?**	☐ Greater than or equal to 18 years of age and requesting Xywav, Xyrem or Lumryz - Proceed to question **7** ☐ Greater than or equal to 7 years of age but less than 18 years of age and requesting Xywav or Xyrem – Proceed to question **8** ☐ Other – **STOP Coverage not approved**	

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Question		
5. What is the requested medication?	☐ Lumryz, Xyrem **STOP Coverage not approved**	☐ Xywav Proceed to question **6**
6. How old is the patient?	☐ 18 years of age or older - Proceed to question **9** ☐ Other – **STOP Coverage not approved**	
7. Does the patient have a history of failure, contraindication, or intolerance to modafinil or armodafinil?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Does the patient have a history of failure, contraindication, or intolerance to a stimulant- based therapy (amphetamine-based therapy or methylphenidate)?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Is a neurologist, psychiatrist, or sleep medicine specialist prescribing the requested medication?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Is the patient concurrently taking a central nervous system depressant, such as a narcotic analgesic (including tramadol), a benzodiazepine, or a sedative hypnotic?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

† Coverage is NOT provided for the treatment of other conditions not listed above or any non-FDA approved use, including: fibromyalgia, insomnia, and excessive sleepiness not associated with narcolepsy.

Step 3 **I certify the above is true to the best of my knowledge.**
Please sign and date:

_______________________________ Prescriber Signature

_______________ Date

[7 Dec 2023]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: