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

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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 and cataplexy in a patient with narcolepsy - Proceed to question **3** ☐ Excessive daytime sleepiness in a patient with narcolepsy - Proceed to question **3** ☐ 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. What is the patient's age?	☐ 18 years of age or older - Proceed to question **5** ☐ GREATER than or equal to 7 years of age but less than 18 years of age – Proceed to question **6** ☐ Less than 7 years of age – **STOP Coverage not approved**	
5. Does the patient have a history of failure, contraindication, or intolerance to modafinil or armodafinil?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. 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 **7**	☐ No **STOP** **Coverage not approved**

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7. Is the requested medication being prescribed by a neurologist, psychiatrist, or sleep medicine specialist?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. 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

[10 February 2021]

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