Xywav (calcium, potassium, magnesium, sodium oxybates) Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL**		**IF RENEWAL:** DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

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CAT0290

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Narcolepsy with cataplexy ☐ Narcolepsy with excessive daytime sleepiness ☐ Other Diagnosis_____ICD-10 Code(s):_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

For <u>all diagnoses,</u> answer the following:
Is the prescriber a sleep specialist or neurologist? ☐ Yes ☐ No

Has patient had a minimum 3month trial of immediate release sodium oxybate? ☐ Yes ☐ No *Please submit supporting documentation.*

If patient has tried immediate release sodium oxybate, did patient fail to have their narcolepsy with excessive daytime sleepiness or cataplexy resolved? ☐ Yes ☐ No *Please submit supporting documentation.*

Does patient have an absolute contraindication to immediate release sodium oxybate, such as hypertension, congestive heart failure and or chronic kidney disease? ☐ Yes ☐ No *Please submit supporting documentation.*

Select if the following applies to the patient:*
- ☐ **A polysomnography (PSG) sleep study consistent with narcolepsy**
- ☐ **A Multiple Sleep Latency Test consistent with narcolepsy**
- ☐ **Chart notes or consultation report documenting diagnosis**

Please provide supporting documentation.

For <u>narcolepsy with excessive daytime sleepiness</u>, also answer the following:
Is the patient concurrently taking a sedative hypnotic? ☐ Yes ☐ No

Has the patient had a previous trial with standard stimulants such as methylphenidate, dextroamphetamine, or amphetamine/dextroamphetamine?* ☐ Yes ☐ No
Please submit supporting documentation showing date(s) of trial(s).

Has the patient had a previous trial with generic modafinil (Provigil) or Nuvigil (armodafinil)?* ☐ Yes ☐ No
Please submit supporting documentation.

<u>If "no"</u> to the above question, is the patient not a candidate for generic modafinil (Provigil) or armodafinil(Nuvigil)?* ☐ Yes ☐ No
Please submit supporting documentation.

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: Not all drugs/diagnoses are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP - 4201
P.O. Box 64811
St. Paul, MN 55164-0811

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CAT0290