US Family Health Plan
Prior Authorization Request Form for
sodium oxybate (**Xyrem**), calcium, magnesium, potassium & sodium oxybate salts (**Xywav**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Medical documentation may be required. Failure to provide could result in denial.
Prior authorization will expire in one year after approval.

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** ☐ 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?	☐ 18 years of age or older - Proceed to question **7** ☐ GREATER than or equal to 7 years of age but less than 18 years of age – Proceed to question **8** ☐ Less than 7 years of age – **STOP Coverage not approved**	
5. What is the requested medication?	☐ Xyrem **STOP Coverage not approved**	☐ Xywav Proceed to question **6**

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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 the requested medication being prescribed by a neurologist, psychiatrist, or sleep medicine specialist?	☐ 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 _____