**Antinarcolepsy: Xyrem and Xywav**

**Beneficiary Information**

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| 1. Beneficiary Last Name: 2. First Name:  3. Beneficiary ID #: 4. Beneficiary Date of Birth: 5. Beneficiary Gender: |

**Prescriber Information**

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| 6. Prescribing Provider NPI #:  7. Requester Contact Information - Name: Phone #: Ext. |

**Drug Information**

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| 8. Drug Name: 9. Strength: 10. Quantity Per 30 Days:  11. Length of Therapy (in days): Initial Authorization:  up to 30 Days  60 Days  90 Days  Reauthorization:  up to 30 Days  60 Days  90 Days  120 Days  180 Days |

**Clinical Information**

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| 1. Is the beneficiary 7 years of age or older?  **Yes**  **No**  2. Does the beneficiary have any current use of alcohol or sedative hypnotics?  **Yes**  **No**  3. Does the beneficiary have succinic semialdehyde dehydrogenase deficiency  **Yes**  **No**  4. Has the beneficiary been evaluated for history of drug abuse?  **Yes**  **No**  5. Will the prescriber monitor the beneficiary for signs of misuse or abuse of sodium oxybate (a.k.a. gamma-hydroxybutyrate  [GHB]) including, but not limited to, the following: Use of increasingly large doses, increased frequency of use, drug seeking  behavior, feigned cataplexy, etc.?  **Yes**  **No**  6. Does the beneficiary have a diagnosis of cataplexy associated with narcolepsy?  **Yes**  **No**  7. Does the beneficiary have a diagnosis of excessive daytime sleepiness due to narcolepsy with dayly periods of irrepressible  need to sleep or daytime lapses into sleep occurring for > 3 months?  **Yes**  **No**  8. Does the beneficiary have hypersomnolence secondary to another sleep disorder, neurologic disorder, medical condition, or by  medicine or substance use has been ruled out?  **Yes**  **No**  **For continuation of therapy, please answer questions 1-10**  9. For a diagnosis of excessive daytime sleepiness, has the beneficiary responded to therapy with a reduction in excessive daytime  sleepiness from pre-treatment baseline measured by a validated scale (e.g., Epworth Sleepiness Scale, Stanford Sleepiness  Scale, Karolinska Sleepiness Scale, Cleveland Adolescent Sleepiness Questionnaire, or a Visual Analog Scale)?  **Yes**  **No**  10. For a diagnosis of cataplexy, has the beneficiary had a reduced frequency of cataplexy attacks from pretreatment baseline?  **Yes**  **No** |

Signature of Prescriber: Date:

**(Prescriber Signature Mandatory)**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.