**Antinarcolepsy: Xyrem and Xywav**

**Beneficiary Information**

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

**Prescriber Information**

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

**Drug Information**

|  |
| --- |
| 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**

|  |
| --- |
| 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.