Xyrem® (sodium oxybate)
Prior Authorization Form

ROCKY MOUNTAIN HEALTH PLANS®
We understand Colorado. We understand you.

Complete Patient and Physician information (PLEASE PRINT)

STEP 1

Member Name:	Physician Name:
Address:	Address:
Member ID:	Phone #:
Member DOB:	Fax #:
	Tax ID or NPI #:

If Applicable: Pharmacy Name: _____
Pharmacy Phone: _____

Complete the Clinical Assessment:

Please attach all relevant medical records and test results

STEP 2

Diagnosis	☐ Narcolepsy ☐ Cataplexy ☐ Excessive Daytime Sleepiness ***Xyrem is only approved for the treatment of cataplexy or Excessive Daytime Sleepiness in patients with narcolepsy***	☐ Other (clinical notes related to diagnosis required): _____
Physician Specialty	Original diagnosis must be made by Neurologist or Sleep disorder specialist. Primary care provider may make subsequent requests. ☐ Neurologist ☐ Sleep Disorder Specialist ☐ Other _____ Name of Doctor who made original diagnosis _____	
Supporting Documentation Included ☐	Diagnosis: ICD-9 Code #/ Description / J Code (required): Please attach a copy of the prescription or provide ALL of the information below: Xyrem® (sodium oxybate) Strength _____ Sig _____ Qty _____ Refills _____	
	Incomplete forms will not be processed.	

STEP 3

I certify that the above is correct and accurate to the best of my knowledge (please sign and date).

_____ _____
Prescriber Signature Date

STEP 4

Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:

970-248-5034

Name of Person filling out form: _____

Pharmacy Technician initials _____ Date Initiated _____

Confidentiality Notice:

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