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	☐ Other (clinical notes related to diagnosis required): _____
	Xyrem is only approved for the treatment of cataplexy or Excessive Daytime Sleepiness in patients with narcolepsy	
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-9/10 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	
	We will not process incomplete forms. **If we do not receive the completed form & all relevant medical records & test results within 10 calendar days of this request, it will be denied.**	

STEP 3

I certify that the above is correct and accurate to the best of my knowledge and that the form is complete. (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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04/13/10