

**NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Antinarcology: 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: <input type="checkbox"/> up to 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days <input type="checkbox"/> 120 Days <input type="checkbox"/> 180 Days <input type="checkbox"/> 365 Days		
Reauthorization: <input type="checkbox"/> up to 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days <input type="checkbox"/> 120 Days <input type="checkbox"/> 180 Days <input type="checkbox"/> 365 Days		

Clinical Information

For diagnoses of Cataplexy or Excessive Daytime Sleepiness (EDS) associated with Narcolepsy (questions 1-8)

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 daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for \geq 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 Diagnosis of Idiopathic Hypersomnia (questions 9- 17)

9. Does the beneficiary have a diagnosis of idiopathic hypersomnia with daytime lapses into sleep or an irrepressible need to sleep on a daily basis for \geq 3 months? Yes No

10. Is insufficient sleep syndrome confirmed as absent? Yes No

11. Does Multiple Sleep Latency Test (MSLT) show fewer than 2 sleep onset REM periods (SOREMPs, which are REM sleep periods within 15 minutes of sleep onset) or no SOREMPs, if the REM latency on the preceding overnight sleep study was less than or equal to 15 minutes? Yes No

12. Is the average sleep latency less than or equal to 8 minutes on MSLT? Yes No

13. Is the total 24- hour sleep time greater than or equal to 660 minutes? Yes No

14. Does the beneficiary have cataplexy? Yes No

15. Has hypersomnolence secondary to another sleep disorder, neurologic disorder, medical condition, or by medicine or substance use been ruled out? Yes No

16. Is the beneficiary \geq 18 years of age? Yes No

17. Has the beneficiary tried and failed on a preferred formulation of modafinil or does the beneficiary have a contraindication or intolerance to an adequate trial with preferred formulation of modafinil? Yes No

For continuation of therapy, please answer questions above and below relative to the beneficiary's diagnosis.

18. For a diagnosis of Excessive Daytime Sleepiness or Idiopathic Hypersomnia, 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

19. 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.

Fax this form to: (833) 404-2393

Pharmacy PA Call Center: (833) 585-4309

<https://www.covermyeds.com/main/prior-authorization-forms/>