Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Xyrem/Xywav (Oxybate products) (Medicaid)

This fax machine is located in a secure location as required by HIPAA Regulations. Complete / Review information, sign, and date. Fax signed forms to Molina Pharmacy Prior Authorization Department at **1-888-487-9251**. Please contact Molina Pharmacy Prior Authorization Department at **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Xyrem/Xywav (Oxybate products) (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)	
XYREM 500 MG/ML ORAL SOLUTION	XYWAV 0.5 G/ML SOLUTION

Patient Information	
Patient Name:	
Patient ID:	
Patient DOB:	

Prescribing Physician	
Physician Name:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State, Zip:	

Diagnosis:	ICD Code:
Directions for administration:	

*****Please include all relevant clinical notes, lab work, medication history and any other applicable documentation.**

Please circle the appropriate answer for each question.

1. Is the requested drug required per court order? (court order required) Y N
   If the answer to this question is yes, approved for 365 days.
   If the answer to this question is no, go to question 2.

2. Is the medication being prescribed by, or in consultation with, a neurologist or sleep specialist or has the patient had a sleep study with a sleep latency test? Y N
   If the answer to this question is yes, go to question 3.
   If the answer to this question is no, denied.

3. Is the patient less than 7 years of age? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 4.

4. Does the patient have a diagnosis of alcohol or substance abuse in the last 730 days? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 5.

5. Does the patient have a claim for a Central Nervous System (CNS) depressant agent in the last 60 days? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 6.

6. Is the requested dose per day less than or equal to 9 grams? Y N
   If the answer to this question is yes, go to question 7.
   If the answer to this question is no, denied.

7. Does the patient have a diagnosis of narcolepsy or cataplexy in the last 730 days? Y N
   If the answer to this question is yes, go to question 8.
   If the answer to this question is no, denied.

8. Does the patient have a contraindication or intolerance to alternative stimulant agents to treat narcolepsy in cataplexy, narcolepsy or excessive daytime sleepiness in narcolepsy? Y N
   [Note: Documentation of previous therapies and contraindication or intolerance is required. Please include in notes below.]
   If the answer to this question is yes, go to question 9.
   If the answer to this question is no, denied.

9. Has the prescriber documented that the patient is enrolled in the Xywav and Xyrem Risk Evaluation and Mitigation Strategy (REMS) Program? Y N
   If the answer to this question is yes, go to question 10.
   If the answer to this question is no, denied.

10. Is the prescriber enrolled in the Xywav and Xyrem REMS Program? Y N
    If the answer to this question is yes, go to question 11.
    If the answer to this question is no, denied.

11. Is the patient currently using alcohol or illicit drugs? Y N
    If the answer to this question is yes, denied.
    If the answer to this question is no, go to question 12.

12. Is the request for a non-preferred drug? Y N
    If the answer to this question is yes, go to question 13.
    If the answer to this question is no, approved for 365 days.

13. Has the patient failed a treatment trial with at least 1 preferred agent? Y N
    If the answer to this question is yes, approved for 365 days.
    If the answer to this question is no, go to question 14.

14. Is there a documented allergy or contraindication to preferred agents in this class? Y N
    If the answer to this question is yes, approved 365 days.
    If the answer to this question is no, go to question 15.

15. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? Y N
    If the answer to this question is yes, approved 365 days.
    If the answer to this question is no, denied.

Comments:

I affirm that the information given on this form is true and accurate as of this date.

_____ _____

Prescriber (or Authorized) Signature Date