aetna™

Aetna Better Health®

Fax completed prior authorization request form to 844-802-1412 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at https://www.aetnabetterhealth.com/Illinois-medicaid

Xyrem
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information				
What medication(s) has the member tried and failed for this diagnosis? Please specify:				
Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): ☐ Yes ☐ No	Diagnosis:			ICD-10 Code:
Are there any contraindications to formulary medications? If yes, please specify:	☐ Yes	☐ No	☐ New request	☐ Continuation of therapy request
Directions for Use:	Strength:		Dosage Form:	
	Quantity:	Day Supply:	Duration of Therapy/Use:	

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Information						
☐ **Severe Narcolepsy with cataplexy** ☐ **Severe Narcolepsy with excessive daytime sleepiness**						
Are BOTH, prescriber and member, enrolled in the Xyrem Risk Evaluation and Mitigation Strategy (REMS) Program?					☐ Yes	☐ No
Does member have succinic semialdehyde dehydrogenase deficiency?	☐ Yes	☐ No	Is member currently on ANY Central Nervous System (CNS) depressants?		☐ Yes	☐ No
Was a polysomnography completed?					☐ Yes	☐ No
Polysomnography results indicate the following:	☐ At least 6 hours of sleep time occurred during overnight polysomnogram			☐ Other conditions of sleepiness have been ruled out		
Was a Multiple sleep latency test (MSLT) completed?					☐ Yes	☐ No
MSLT was completed AND results indicate the following:	☐ Mean sleep latency is ≤8 min	☐ There are ≥2 Sleep Onset Rapid Eye Movement (SOREM) periods (within 15 min of sleep onset)	☐ SOREM period was identified on polysomnography AND MSLT shows ONE SOREM period			
☐ **Cataplexy**						
Did member have trial and failure, or intolerance	☐ Yes	☐ No	Does member have		☐ Yes	☐ No

with Modafinil for a period of 60-days (PA required)?			contraindication to Modafinil?		
☐ **Excessive Daytime Sleepiness**					
Did member have trial and failure, or intolerance, to 2 CNS stimulants such as amphetamine, dextroamphetamine, or methylphenidate for 60 days at maximum tolerated dose ?	☐ Yes	☐ No	Does member have a contraindication to the CNS stimulants?	☐ Yes	☐ No
Did member have trial and failure, intolerance, or contraindication to Modafinil for 60-days (PA required)?		☐ Yes	☐ No		☐ N/A
☐ **Renewal Request ONLY**					
Does member have concomitant fills for CNS depressants?	☐ Yes	☐ No	Is adherence to Xyrem demonstrated by prescription claims history?	☐ Yes	☐ No
Does response to therapy indicate a decrease in symptoms as demonstrated by Epworth Sleepiness Scale (ESS) and/or Maintenance of Wakefulness Test (MWT)?				☐ Yes	☐ No
Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.					

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 866-329-4701 to check the status of a request.