

## **Nevada Medicaid**

Submit fax request to: 855-455-3303

Please note: All information below is required to process this request.

## Xywav® (oxybate salts) Prior Authorization Request Form DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED.

Member Information (required)				Provider Information (required)				
Member Name:				Provider Name:				
Insurance ID#:				NPI#:		Specialty:		
Date of Birth:				Office Phone:				
Street Address:				Office Fax:				
City	:	State:	Zip:	Office Street Addre	ess:			
Pho	ne:			City:	S	State:	Zip:	
			Madiaatian lufa	rm of on				
Ma	liantian Nama		Medication Info		ed)	Deced		
ivied	dication Name:			Strength:		Dosage Form:	<del>)</del>	
				Directions for Use:				
	Check if request is for <b>contin</b>	uation of the	erany	-				
	oneok ii request is for <b>contin</b>	dation of the						
			Clinical Infor	nation (required	)			
Sel	ect all that apply:							
<ul> <li>The recipient has a diagnosis of narcolepsy as confirmed by a sleep study.</li> <li>The recipient has a diagnosis of narcolepsy, but a sleep study is not feasible (provide justification below).</li> <li>The recipient has symptoms of cataplexy.</li> <li>The recipient has symptoms of excessive daytime sleepiness.</li> <li>The medication is prescribed by or in consultation with one of the following: neurologist, psychiatrist, sleep medicine specialist.</li> <li>If the request is for continuation of therapy, the recipient has all the following:         <ul> <li>A documented response of a reduction in the frequency of cataplexy attacks associated with therapy</li> <li>A documented response of a reduction in symptoms of excessive daytime sleepiness associated with therapy</li> </ul> </li> </ul>								
Dia	gnosis of Narcolepsy wi	thout Cata	plexy (Narcolepsy Ty	pe 2)				
	<ul> <li>The recipient has a diagnosis of narcolepsy, but a sleep study is not feasible (provide justification below).</li> <li>The recipient does not have symptoms of cataplexy.</li> <li>The recipient has symptoms of excessive daytime sleepiness.</li> <li>The recipient had an inadequate response or a contraindication to treatment of all the following:         <ul> <li>Generic Modafinil or generic Armodafinil</li> <li>Sunosi®</li> </ul> </li> <li>The recipient has one of the following:         <ul> <li>An inadequate response or a contraindication to treatment with an amphetamine or methylphenidate-based stimulant</li> </ul> </li> </ul>							
٥		The medication is prescribed by or in consultation with one of the following: neurologist, psychiatrist, sleep medicine						
٥	If the request is for continexcessive daytime sleep			as a documented r	esponse of	a reductio	on in symptoms of	

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?								
Please note:	This request may be denied unless all required information is received. For urgent or expedited requests please call 1-800-711-4555.							

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This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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