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 Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select all that apply:

Narcolepsy with Cataplexy (Narcolepsy Type 1)

- ❑ The recipient has a diagnosis of narcolepsy as confirmed by a sleep study.
- ❑ The recipient has a diagnosis of narcolepsy, but a sleep study is not feasible (provide justification below).
- ❑ The recipient has symptoms of cataplexy.
- ❑ The recipient has symptoms of excessive daytime sleepiness.
- ❑ The medication is prescribed by or in consultation with one of the following: neurologist, psychiatrist, sleep medicine specialist.
- ❑ If the request is for continuation of therapy, the recipient has all the following:
  - A documented response of a reduction in the frequency of cataplexy attacks associated with therapy
  - A documented response of a reduction in symptoms of excessive daytime sleepiness associated with therapy

Diagnosis of Narcolepsy without Cataplexy (Narcolepsy Type 2)

- ❑ The recipient has a diagnosis of narcolepsy as confirmed by a sleep study.
- ❑ The recipient has a diagnosis of narcolepsy, but a sleep study is not feasible (provide justification below).
- ❑ The recipient does not have symptoms of cataplexy.
- ❑ The recipient has symptoms of excessive daytime sleepiness.
- ❑ The recipient had an inadequate response or a contraindication to treatment of all the following:
  - Generic Modafinil or generic Armodafinil
  - Sunosi®
- ❑ The recipient has one of the following:
  - An inadequate response or a contraindication to treatment with an amphetamine or methylphenidate-based stimulant
  - History of or potential for a substance use disorder
- ❑ The medication is prescribed by or in consultation with one of the following: neurologist, psychiatrist, sleep medicine specialist.
- ❑ If the request is for continuation of therapy, the recipient has a documented response of a reduction in symptoms of excessive daytime sleepiness associated with therapy.

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