Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Antinarcolepsy: Xyrem and Xywav

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name:_____ 2. Strength: _____ 3. Quantity per 30 Days: _____
4. Length of Therapy (in Days): **Initial Authorization:** ☐ up to 30 Days ☐ 60 Days ☐ 90 Days
   Reauthorization: ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days

Clinical Information

1. Is the member 7 years of age or older? ☐ **Yes** ☐ **No**
2. Does the member have any current use of alcohol or sedative hypnotics? ☐ **Yes** ☐ **No**
3. Does the member have succinic semialdehyde dehydrogenase deficiency ☐ **Yes** ☐ **No**
4. Has the member been evaluated for history of drug abuse? ☐ **Yes** ☐ **No**
5. Will the prescriber monitor the member 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 member have a diagnosis of cataplexy associated with narcolepsy? ☐ **Yes** ☐ **No**
7. Does the member 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 ≥ 3 months? ☐ **Yes** ☐ **No**
8. Does the member have hypersomnolence secondary to another sleep disorder, neurologic disorder, medical condition, or by medicine or substance use that has been ruled out? ☐ **Yes** ☐ **No**

For continuation of therapy, please answer questions 1-10

9. For a diagnosis of excessive daytime sleepiness, has the member 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**
10. For a diagnosis of cataplexy, has the member 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 PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277