Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Xyrem
(sodium oxybate)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication Requested: ☐ Xyrem ☐ Other (please specify): _____

Directions for use: Quantity: ICD10:

Please provide clinical support for this dosing, including past doses tried and results:

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:
☐ narcolepsy-type 1 ☐ narcolepsy-type 2
☐ narcolepsy-type unknown ☐ other *(please specify):*

Clinical Information

****This drug requires supportive documentation (chart notes, sleep study, etc). Supportive documentation for all answers must be attached with this request****

Will the requested drug be taken concurrently with other sedative hypnotic drugs or alcohol? Yes ☐ No ☐
Does your patient have cataplexy? Yes ☐ No ☐
Is there documentation that your patient has had daily periods of irrepressible need to sleep or lapses into sleep during waking hours, occurring for at least three months? Yes ☐ No ☐
Did your patient undergo a measurement of hypocretin-1 levels in their cerebrospinal fluid (CSF)? Yes ☐ No ☐
(if yes) What was your patient's CSF hypocretin-1 concentration?
- ☐ 110pg/mlL OR less
- ☐ 111pg/mL or higher
- ☐ less than one third of mean values obtained in normal subjects with the same standardized assay
- ☐ more than one third of mean values obtained in normal subjects with the same standardized assay

Did your patient have a nocturnal polysomnography (PSG) to rule out other causes of excessive daytime sleepiness? Yes ☐ No ☐
Did your patient have a multiple sleep latency test (MSLT) that showed a mean sleep latency of 8 minutes or less? Yes ☐ No ☐
Did your patient have any sleep-onset rapid eye movement periods (SOREMPs) during the MSLT?
☐ Yes, 2 or more SOREMPs
☐ Yes, only 1 SOREMP
☐ No or Unknown

Did your patient have a SOREMP within 15 minutes of sleep onset during the nocturnal PSG? Yes ☐ No ☐
(if type 1) Does your patient have documented failure/inadequate response, intolerance, contraindication per FDA label, or is not a candidate for ONE of the following: a tricyclic antidepressant (TCA) (for example, amitriptyline, desipramine, imipramine); a selective serotonin reuptake inhibitor (SSRI) (for example, fluoxetine, sertraline, paroxetine); venlafaxine? Yes ☐ No ☐

(if type 2) Does your patient have other causes of hypersomnolence such as insufficient sleep, obstructive sleep apnea, delayed sleep phase disorder, or the effect of medication or substances or their withdrawal? Yes ☐ No ☐

(if type 2) Does your patient have documented failure/inadequate response, intolerance, contraindication per FDA label, or is not a candidate for modafinil OR armodafinil? Yes ☐ No ☐

(if type 2) Does your patient have documented failure/inadequate response, intolerance, contraindication per FDA label, or is not a candidate for ONE of the following: amphetamine, dextroamphetamine or methylphenidate? Yes ☐ No ☐

Is the requested drug being prescribed by or in consultation with a neurologist, pulmonologist or sleep specialist? Yes ☐ No ☐

Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples of the drug requested, please choose "new start of therapy". ☐ new start ☐ continued therapy

(if type 1) Did your patient have a documented reduction in cataplexy episodes or daily sleep attacks while taking the drug requested? Yes ☐ No ☐

(if type 2) Did your patient have a documented reduction in excessive daytime sleepiness or daily sleep attacks while taking the drug requested? Yes ☐ No ☐

Additional pertinent information

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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