Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Sodium Oxybate, Xywav

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is this a renewal request? If YES, go to 2. If NO, go to 5.

☐ Yes ☐ No

Q2. For narcolepsy with cataplexy, is there documentation of reduction of frequency of cataplexy attacks? If YES, go to 4. If diagnosis is narcolepsy with EDS or idiopathic hypersomnia, go to 3.

☐ Yes ☐ No

Q3. For narcolepsy with EDS or idiopathic hypersomnia, is there documentation of reduction in excessive daytime sleepiness?

☐ Yes ☐ No

Q4. Has the provider checked the PDMP (Pennsylvania Prescription Drug Monitoring Program) before prescribing the medication?

☐ Yes ☐ No

Q5. Is the prescriber a neurologist or sleep specialist?

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Patient Name:	**Prescriber Name:**

☐ Yes	☐ No
Q6. Is the patient 7 years old or older?	
☐ Yes	☐ No
Q7. Are chart notes attached documenting the patient's diagnosis?	
☐ Yes	☐ No
Q8. Does the patient have a diagnosis of narcolepsy? If YES, go to 11. If NO, go to 9.	
☐ Yes	☐ No
Q9. Does the patient have a diagnosis of idiopathic hypersomnia?	
☐ Yes	☐ No
Q10. Has the patient tried and failed or is intolerant to treatment with modafinil or armodafinil? If YES, go to 16.	
☐ Yes	☐ No
Q11. Does the patient have episodes of cataplexy and/or excessive daytime sleepiness?	
☐ For cataplexy, go to 12.	☐ For excessive daytime sleepiness, go to 14.
Q12. For cataplexy, for patients under 18 years old, has the patient tried and failed or is intolerant to treatment with venlafaxine, a tricyclic antidepressant, or an SSRI?	
☐ If YES, go to 16.	☐ If 18 years and older, go to 13.
Q13. For cataplexy, for patients 18 years and older, has the patient tried and failed or is intolerant to treatment with both Wakix and an antidepressant (SNRI, SSRI, or TCA)?	
☐ If YES, go to 16.	☐ If patient has daytime sleepiness, go to 14.

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Patient Name:	**Prescriber Name:**

Q14. For daytime sleepiness, for patients under 18 years old, has the patient tried and failed or is intolerant to treatment with armodafinil or modafinil?

☐ If YES, go to 16. ☐ If 18 years or older, go to 15.

Q15. For daytime sleepiness, for patients 18 years and older, has the patient tried and failed or is intolerant to treatment with all of the following:

a) armodafinil or modafinil,
b) Sunosi,
c) Wakix

☐ Yes ☐ No

Q16. Is the patient currently taking a sedative hypnotic or CNS depressant?

☐ Yes ☐ No

Q17. Was a urine drug screen completed (include most recent date) and consistent with prescribed medications and negative for non-prescribed controlled and illicit substances?

☐ Yes ☐ No

Q18. Has the provider checked the PDMP (Pennsylvania Prescription Drug Monitoring Program) before prescribing the medication?

☐ Yes ☐ No

Q19. Is this a request for a formulary product?

☐ Yes ☐ No

Q20. Is there documentation of an inadequate response, intolerance, or contraindication to all formulary products indicated for the diagnosis that would not be expected to occur with requested agent?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q21. Additional Information:

Prescriber Signature

Date

v2026

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