



MEDICAID / CHIP
PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Xyrem/Xywav - Non-PDL

Phone: 866-841-7659

Fax back to: 866-240-3712

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.

Member Name:		Prescriber Name:	
Member ID Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Member Phone Number:	NPI:	PA PROMISe ID:	
Address:		Address:	
City, State ZIP:		City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP		Specialty Pharmacy (if applicable):	
Drug Name:		Strength:	
Quantity:		Refills:	
Directions:			
Diagnosis Code:		Diagnosis:	

Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..

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 Q16. If no, go to Q2.

☐ Yes

☐ No

Q2. Is the prescriber a neurologist or sleep specialist?

☐ Yes

☐ No

Q3. Is the patient 7 years old or older?

☐ Yes

☐ No

Q4. Does the patient have a diagnosis of narcolepsy? If YES, go to Q7. If NO, go to Q5.

☐ Yes

☐ No

Q5. Does the patient have a diagnosis of idiopathic hypersomnia?

☐ Yes

☐ No

Q6. Has the patient tried and failed or is intolerant to treatment with modafinil or armodafinil? IF YES, go to Q12.



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Member Name:	Prescriber Name:
☐ Yes☐ No	
Q7. Does the patient have episodes of cataplexy and/or excessive daytime sleepiness? ☐ For cataplexy, go to Q8.☐ For excessive daytime sleepiness, go to Q10.	
Q8. 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 Q12.☐ If 18 years and older, go to Q9.	
Q9. 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 Q12.☐ If patient has daytime sleepiness, go to Q10.	
Q10. 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 Q12.☐ If 18 years or older, go to Q11.	
Q11. 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	
Q12. Is the patient currently taking a sedative hypnotic or CNS depressant? ☐ Yes☐ No	
Q13. Was a urine drug screen completed (include most recent date) and consistent with prescribed medications and negative for non-prescribed controlled and illicit substances? IF YES, go to Q14. ☐ Yes☐ No	



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Q14. Has the provider checked the PDMP (Pennsylvania Prescription Drug Monitoring Program) before prescribing the medication?

☐ Yes ☐ No

Q15. Is the request for brand name Xyrem?

☐ Yes ☐ No

Q16. Is there documentation of inadequate response, intolerance, or contraindication to sodium oxybate (generic Xyrem)?

☐ Yes ☐ No

Q17. For narcolepsy with cataplexy, is there documentation of reduction of frequency of cataplexy attacks?

☐ IF YES, go to Q19. ☐ If diagnosis is narcolepsy with EDS or idiopathic hypersomnia, go to Q18.

Q18. For narcolepsy with EDS or idiopathic hypersomnia, is there documentation of reduction in excessive daytime sleepiness?

☐ Yes ☐ No

Q19. Has the provider checked the PDMP (Pennsylvania Prescription Drug Monitoring Program) before prescribing the medication?

☐ Yes ☐ No

Q20. Additional Information:

Prescriber Signature

Date

v2026-06