UnitedHealthcare Community Plan

NC Pharmacy Prior Approval Request for
Antinarcolepsy: Xywav

Beneficiary Information

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

Prescriber Information

6. Prescribing Provider NPI #: _____ Provider Fax #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): Initial Authorization: ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days
Reauthorization: ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

For diagnoses of Cataplexy or Excessive Daytime Sleepiness (EDS) associated with Narcolepsy (questions 1-8)

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

For Diagnosis of Idiopathic Hypersomnia (questions 9- 17)

9. Does the beneficiary have a diagnosis of idiopathic hypersomnia with daytime lapses into sleep or an irrepressible need to sleep on a daily basis for ≥ 3 months? ☐ **Yes** ☐ **No**
10. Is insufficient sleep syndrome confirmed as absent? ☐ **Yes** ☐ **No**
11. Does Multiple Sleep Latency Test (MSLT) show fewer than 2 sleep onset REM periods (SOREMPs, which are REM sleep periods within 15 minutes of sleep onset) or no SOREMPs, if the REM latency on the preceding overnight sleep study was less than or equal to 15 minutes? ☐ **Yes** ☐ **No**
12. Is the average sleep latency less than or equal to 8 minutes on MSLT? ☐ **Yes** ☐ **No**
13. Is the total 24- hour sleep time greater than or equal to 660 minutes? ☐ **Yes** ☐ **No**
14. Does the beneficiary have cataplexy? ☐ **Yes** ☐ **No**
15. Has hypersomnolence secondary to another sleep disorder, neurologic disorder, medical condition, or by medicine or substance use been ruled out? ☐ **Yes** ☐ **No**
16. Is the beneficiary ≥ 18 years of age? ☐ **Yes** ☐ **No**
17. Has the beneficiary tried and failed on a preferred formulation of modafinil or does the beneficiary have a contraindication or intolerance to an adequate trial with preferred formulation of modafinil? ☐ **Yes** ☐ **No**

For continuation of therapy, please answer questions above and below relative to the beneficiary's diagnosis.

18. For a diagnosis of Excessive Daytime Sleepiness or Idiopathic Hypersomnia, has the beneficiary 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**
19. For a diagnosis of Cataplexy, has the beneficiary 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 1-866-940-7328 Pharmacy PA Call Center: 1-855-258-1593