Catamaran Prior Authorization Department
Phone: 800-626-0072
Fax: 866-511-2202
Catamaran (UHA's Pharmacy Benefits Manager)

Prescriber Information

Last Name:	**First Name**
DEA/NPI:	**Specialty:**
Phone - -	**Fax** - -

Member Information

Last Name:	**First Name**
Member ID Number	**DOB:** - -

Medication Information:

Drug Name and Strength:	Quantity and Dosing:
Diagnosis:	Duration:

Complete the below Medical Benefit section if the request is for an injectable medication that is covered under the medical benefit only, yet requires a prior authorization.

Medical Benefit:

ICD Code:	Billing units (per dose):
J-Code:	Frequency of Administration:
NDC Number:	Retro-authorization for the following date(s) of service:

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Xyrem Prior Authorization

Initial Therapy You must answer ALL of the following questions		
1. Is this a first time request for this medication under the patient's pharmacy benefit? **(Please Circle)** ☐ Yes ☐ No ☐ Unknown *This will be verified in the patient's claims history. If not found, patient will be subject to initial criteria. *To avoid delay in coverage determination, please fill out the initial section of the form if this is unknown.** *If No, please complete Repeat Therapy section below*		
2. Are the patient and physician enrolled in the Xyrem Success Program?	Y	N
3. Will the patient use the prescribed medication in combination with a sedative hypnotic agent or alcohol?	Y	N
4. Does the patient have a succinic semialdehyde dehydrogenase deficiency?	Y	N
5. What is the patient's diagnosis? **(Please Circle)** ☐ Narcolepsy with excessive daytime sleepiness ☐ Cataplexy in narcolepsy ☐ Other: _____		
6. Has the patient had a trial and inadequate response, contraindication, or intolerance to an amphetamine or methylphenidate product (e.g., methylphenidate, dextroamphetamine, or mixed amphetamine salt)?	Y	N
7. Has the patient had a trial and inadequate response, contraindication or intolerance to a CNS stimulant (e.g., modafinil (Provigil), armodafinil (Nuvigil))?	Y	N

Repeat Therapy You must answer ALL of the following questions		
1. Is this a first time request for this medication under the patient's pharmacy benefit? **(Please Circle)** ☐ Yes ☐ No ☐ Unknown *This will be verified in the patient's claims history. If not found, patient will be subject to initial criteria. *To avoid delay in coverage determination, please fill out the initial section of the form if this is unknown.** *If Yes, please complete Initial Therapy section above*		
2. Is the patient benefiting from therapy as evidenced by improved wakefulness or reduced fatigue?	Y	N
3. Is the patient concomitantly receiving a sedative hypnotic agent or alcohol?	Y	N

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Comments: _____

Information given on this form is accurate as of this date.

_____ _____

Prescriber or Authorized Signature **Date**

_____

Authorized Medical Staff – Name/Title

Attention Healthcare Provider: If you would like to discuss this request with a medical professional, please contact the Prior Authorization Department at 800-626-0072.

I understand that Catamaran's use or disclosure of individually identifiable health information, whether furnished by me or obtained by another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).