

**Physician's Prior Authorization Questionnaire
Xyrem®**

Patient:

ID#:

DOB:

Patient Address:

Xyrem® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

Is this an initial request for approval? Yes No

If Yes, answer questions 1 thru 5 and submit this form along with the last 12 months of medical records verifying diagnosis and informed risk. A follow-up approval for continued coverage must be obtained after the first 3 months of therapy for continued coverage. Six month coverage will be available thereafter.

Is this a request for continued approval? Yes

If Yes, skip questions and submit this form with current medical records since last approval date.

1. What is the patient's diagnosis? *(Please do not use codes.)* _____

2. Please list previous medication therapies and duration:

Medication	Duration of Therapy	Reason Discontinued
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. List all current medications: _____

4. Does this patient ever use alcoholic beverages? Yes No

5. What dose is being requested (mg/day)? _____

Xyrem® is only covered for 180ml per prescription.

Physician's Signature

Date

Please **Print** Physician's Name & Specialty

Phone Number

Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx