

XYREM®
PRIOR AUTHORIZATION
PHYSICIAN FAX FORM



BlueCross BlueShield
of Illinois

ONLY the prescriber may complete this form.

Incomplete forms will be returned for additional information. The following documentation is required for preauthorization consideration. For formulary information and to download additional forms, please visit www.bcbsil.com

Today's Date: _____

PATIENT INFORMATION

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip	Patient Telephone:	

INSURANCE INFORMATION

BCBS ID Number:	Group Number:
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PHYSICIAN/CLINIC INFORMATION

Prescriber Name:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient Diagnosis – ICD-9 code plus description:	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
<p>1. Please note previous medications the patient has tried and failed for this diagnosis:</p> <p><input type="checkbox"/> amphetamine/dextroamphetamine</p> <p><input type="checkbox"/> dextroamphetamine</p> <p><input type="checkbox"/> methylphenidate</p> <p><input type="checkbox"/> Nuvigil</p> <p><input type="checkbox"/> Provigil</p> <p><input type="checkbox"/> Other _____</p>	
<p>2. Does the patient have an allergy, contraindication, or intolerance to standard stimulant treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Does the patient have succinic semialdehyde dehydrogenase deficiency? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Is the patient being treated with any sedative hypnotic agents? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Does the patient have a history of substance abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Is the patient enrolled in the Xyrem Success Program? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Please list all reasons for selecting the requested medication over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives.) _____</p> <p>_____</p> <p>_____</p>	

Please fax or mail this form to:

Prime Therapeutics LLC
 Clinical Review Department
 1305 Corporate Center Drive
 Eagan, Minnesota 55121

TOLL FREE

Fax: 877.480.8130 Phone: 888.271.3183

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