



**SODIUM OXYBATE (XYREM®)
PRIOR REVIEW/CERTIFICATION FAXBACK FORM**

**INCOMPLETE FORMS MAY DELAY PROCESSING
ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT BCBSNC PROVIDER ID# BELOW**

PRESCRIBER INFORMATION		PATIENT INFORMATION
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH
PRACTICE ADDRESS	CITY	STATE ZIP

Xyrem is indicated for the treatment of excessive daytime sleepiness and cataplexy in patients with narcolepsy.

Please answer the following questions:

Dx Code: _____

- Is the patient 18 years of age or older? Yes No
- Does the patient have a diagnosis of narcolepsy?..... Yes No
- Has the patient had a polysomnogram (with at least 6 hours of sleep time) that showed the absence of other pathology which would cause excessive daytime sleepiness? Yes No
- Has the patient had a multiple sleep latency test that confirmed the diagnosis of narcolepsy? Yes No

Please certify the following by signing and dating below:

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required): _____ Date: _____

For BCBSNC members, fax form to 1-800-795-9403