maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Lumryz/Xyrem/Xywav

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	Is the requested medication prescribed by a sleep specialist physician or a neurologist? [If no, no further questions.]	Yes	No
2	Is the requested medication being used in combination with Wakix (pitolisant tablets), Sunosi (solriamfetol tablets), sedative hypnotics, or central nervous system depressants? [If yes, no further questions.]	Yes	No
3	Is the patient enrolled in the Lumryz, Xyrem or Xywav REMS program? [If no, no further questions.]	Yes	No

If you have any questions, call:
1-888-258-8250

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4	What is the indication or diagnosis? [] Cataplexy Treatment in a Patient with Narcolepsy (If checked, go to 5) [] Excessive Daytime Sleepiness in a Patient with Narcolepsy (If checked, go to 5) [] Idiopathic Hypersomnia (If checked, go to 19) [] Fibromyalgia (If checked, no further questions) [] Other (If checked, no further questions)		
5	Is the patient greater than or equal to 7 years of age? [If no, no further questions.]	Yes	No
6	Is the patient currently receiving requested medication? [If no, skip to question 13.]	Yes	No
7	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 13.]	Yes	No
8	Does the patient have a previously approved PA on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If yes, skip to question 10.]	Yes	No
9	Has documentation been submitted to confirm that the provider has a documented clinical response of the patient's condition which has stabilized or improved based upon the prescriber's assessment? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 13.] [If no, no further questions.]	Yes	No
10	Has the patient been established on the requested medication for at least 90 days? [Note: A patient who has received less than 90 days of therapy or who is restarting therapy is reviewed under initial therapy.] [If no, skip to question 13.]	Yes	No
11	Has documentation been submitted to confirm that the patient has had a clinical response, defined as improvement from baseline (prior to initiating the requested medication)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
12	Does the patient have a reduction in symptoms of excessive daytime sleepiness? [No further questions.]	Yes	No
13	Has documentation been submitted to confirm that the patient has had an	Yes	No

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	evaluation using polysomnography and has a multiple sleep latency test of 8 minutes or less? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]		
14	Has documentation been submitted to confirm the patient's diagnosis? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
15	Does the patient have daily periods of irrepressible need to sleep occurring for at least three months? [If no, no further questions.]	Yes	No
16	Have other causes of sleepiness have been ruled out or treated (for example, obstructive sleep apnea, insufficient sleep syndrome, shift work, effect of substances or medications, other sleep disorders)? [If no, no further questions.]	Yes	No
17	Does the patient have a condition which would require a restricted intake of sodium? [If yes, no further questions.]	Yes	No
18	Has documentation been submitted to confirm that the patient has had a trial and failure of 3 months, has a contraindication to, or an intolerance to at least two oral medications used to treat narcolepsy-related excessive daytime sleepiness? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
19	Is the requested medication for Xywav? [If no, no further questions.]	Yes	No
20	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
21	Is the patient currently receiving the requested medication? [If no, skip to question 28.]	Yes	No
22	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 28.]	Yes	No
23	Does the patient have a previously approved PA on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If yes, skip to question 25.]	Yes	No
24	Has documentation been submitted to confirm that the provider has a documented clinical response of the patient's condition which has stabilized or improved based upon the prescriber's assessment? ACTION REQUIRED: Submit supporting	Yes	No

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	documentation. [If yes, skip to question 28.] [If no, no further questions.]		
25	Has the patient been established on the requested medication for at least 90 days? [Note: A patient who has received less than 90 days of therapy or who is restarting therapy is reviewed under initial therapy.] [If no, skip to question 28.]	Yes	No
26	Has documentation been submitted to confirm that the patient has had a clinical response, defined as improvement from baseline (prior to initiating the requested medication)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
27	Does the patient have a reduction in symptoms of excessive daytime sleepiness? [No further questions.]	Yes	No
28	Has documentation been submitted to confirm that the patient has had an evaluation using polysomnography and has a multiple sleep latency test of 8 minutes or less? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
29	According to the prescriber, are the results of the polysomnography and a multiple sleep latency test congruent with a diagnosis of idiopathic hypersomnia? [If no, no further questions.]	Yes	No
30	Does the patient have daily periods of irrepressible need to sleep occurring for at least three months? [If no, no further questions.]	Yes	No
31	Have other causes of sleepiness have been ruled out or treated (for example, obstructive sleep apnea, insufficient sleep syndrome, shift work, effect of substances or medications, other sleep disorders)? [If no, no further questions.]	Yes	No
32	Does the patient have a condition which would require a restricted intake of sodium? [If yes, no further questions.]	Yes	No
33	Has documentation been submitted to confirm that the patient has had a trial and failure of 3 months, has a contraindication to, or an intolerance to at least two oral medications used to treat hypersomnia-related excessive daytime sleepiness? ACTION REQUIRED: Submit supporting documentation.	Yes	No

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Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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