# PRIOR AUTHORIZATION REQUEST

## LUMRYZ

**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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1 Is the request for an INITIAL or a CONTINUATION of therapy?

[] Initial (If checked, go to 7)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No
[If no, skip to question 7.]

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

Version 04.2026

# PRIOR AUTHORIZATION REQUEST

| | | | |
|---|---|---|---|
| 3 | Has the patient been receiving medication samples of the requested medication?<br>[If yes, skip to question 7.] | Yes | No |
| 4 | Does the patient have a previously approved prior authorization (PA) on file with the current plan?<br>[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.]<br>[If no, skip to question 7.] | Yes | No |
| 5 | Has the patient been established on therapy for AT LEAST 3 months?<br>[If no, skip to question 7.] | Yes | No |
| 6 | Has documentation been submitted to confirm that the patient has had a clinically significant response, as determined by the provider? ACTION REQUIRED: Submit supporting documentation.<br>[No further questions.] | Yes | No |
| 7 | What is the indication or diagnosis?<br>[] Cataplexy Treatment in a Patient with Narcolepsy (If checked, go to 8)<br>[] Excessive Daytime Sleepiness in a Patient with Narcolepsy (If checked, go to 8)<br>[] Idiopathic Hypersomnia (If checked, go to 19)<br>[] Fibromyalgia (If checked, no further questions)<br>[] Other (If checked, no further questions) | | |
| 8 | Is the patient greater than or equal to 7 years of age?<br>[If no, no further questions.] | Yes | No |
| 9 | Has documentation been submitted to confirm that the patient has a mean sleep latency less than or equal to 8 minutes and two or more sleep onset REM periods (SOREMPs) on an MSLT performed according to standard techniques following a normal overnight polysomnogram? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 10 | Has documentation been submitted to confirm the patient's diagnosis? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 11 | Does the patient have daily periods of irrepressible need to sleep occurring for AT LEAST 3 months?<br>[If no, no further questions.] | Yes | No |
| 12 | Have other causes of sleepiness been ruled out or treated (for example, | Yes | No |

# PRIOR AUTHORIZATION REQUEST

| | | | |
|---|---|---|---|
| | obstructive sleep apnea, insufficient sleep syndrome, shift work, effect of substances or medications, other sleep disorders)?<br>[If no, no further questions.] | | |
| 13 | Does the patient have a condition which would require a restricted intake of sodium?<br>[If yes, no further questions.] | Yes | No |
| 14 | Has documentation been submitted to confirm that the patient has had a trial and failure for AT LEAST 3 months, with AT LEAST 2 oral medications used to treat narcolepsy-related excessive daytime sleepiness unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 15 | Is the requested medication being used in combination with Wakix (pitolisant tablets), Sunosi (solriamfetol tablets), sedative hypnotics, or central nervous system depressants?<br>[If yes, no further questions.] | Yes | No |
| 16 | Is the patient enrolled in the Lumryz, Xyrem or Xywav REMS program?<br>[If no, no further questions.] | Yes | No |
| 17 | Is the requested medication being prescribed by or in consultation with a sleep specialist physician or a neurologist?<br>[If no, no further questions.] | Yes | No |
| 18 | Does the dose of the requested medication exceed Food and Drug Administration (FDA) approved label dosing for the indication?<br>[Dosing: Loading dose of 4.5 g daily and maintenance: 6 g to 9 g daily.]<br>[No further questions.] | Yes | No |
| 19 | Is the requested medication for Xywav?<br>[If no, no further questions.] | Yes | No |
| 20 | Is the patient greater than or equal to 18 years of age?<br>[If no, no further questions.] | Yes | No |
| 21 | 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.<br>[If no, no further questions.] | Yes | No |
| 22 | According to the prescriber, are the results of the polysomnography and a multiple sleep latency test congruent with a diagnosis of idiopathic hypersomnia?<br>[If no, no further questions.] | Yes | No |
| 23 | Does the patient have daily periods of irrepressible need to sleep occurring for AT LEAST 3 months? | Yes | No |

# PRIOR AUTHORIZATION REQUEST

| | | | |
|---|---|---|---|
| | [If no, no further questions.] | | |
| 24 | Have other causes of sleepiness been ruled out or treated (for example, obstructive sleep apnea, insufficient sleep syndrome, shift work, effect of substances or medications, other sleep disorders)?<br>[If no, no further questions.] | Yes | No |
| 25 | Does the patient have a condition which would require a restricted intake of sodium?<br>[If yes, no further questions.] | Yes | No |
| 26 | Has documentation been submitted to confirm that the patient has had a trial and failure for AT LEAST 3 months, with AT LEAST 2 oral medications used to treat hypersomnia-related excessive daytime sleepiness? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 27 | Is the requested medication being used in combination with Wakix (pitolisant tablets), Sunosi (solriamfetol tablets), sedative hypnotics, or central nervous system depressants?<br>[If yes, no further questions.] | Yes | No |
| 28 | Is the patient enrolled in the Xywav REMS program?<br>[If no, no further questions.] | Yes | No |
| 29 | Is the requested medication being prescribed by a sleep specialist physician or a neurologist?<br>[If no, no further questions.] | Yes | No |
| 30 | Does the dose of the requested medication exceed Food and Drug Administration (FDA) approved label dosing for the indication?<br>[Dosing: Loading dose of 4.5 g daily and maintenance: 6 g to 9 g daily.] | Yes | No |

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

SECTION B: Physician Signature

# PRIOR AUTHORIZATION REQUEST

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.

**Confidentiality:** The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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

Version 04.2026