PRIOR AUTHORIZATION REQUEST

Voxzogo

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	What is the diagnosis or indication? [] Achondroplasia (If checked, go to #2) [] Hypochondroplasia, Thanatophoric Dysplasia, or other Short Stature Conditions other than Achondroplasia (for example, trisomy 21, pseudoachondroplasia) (If checked, no further questions.] [] Other (If checked, no further questions)		
2	Will the requested medication be used concurrently with other growth hormones (for example, somatropin), long-acting growth hormones [for example, Ngenla (somatrogon-ghla), Skytrofa (lonapegsomatropin), Sogroya (somapacitan-beco)],	Yes	No

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1-888-258-8250

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	or insulin-like growth factor- 1 (IGF-1) [for example, Increlex (mecasermin)] agents? [If yes, no further questions.]		
3	How old is the patient? [] Less than 5 years of age (If checked, no further questions) [] Greater than or equal to 5 years of age and less than 18 years of age (If checked, go to #4) [] Greater than or equal to 18 years of age (If checked, no further questions)		
4	Will the patient have limb-lengthening surgery during treatment with the requested medication? [If yes, no further questions.]	Yes	No
5	Has the prescriber confirmed that the patient is able to drink approximately 240 to 300 mL of fluid in the hour prior to the requested medication administration? [If no, no further questions.]	Yes	No
6	Is the requested medication being prescribed by or in consultation with a pediatric endocrinologist? [If no, no further questions.]	Yes	No
7	Is the patient currently receiving the requested medication? [If no, skip to question 11.]	Yes	No
8	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 11.]	Yes	No
9	Does the patient have a previously approved prior authorization (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 no, skip to question 11.]	Yes	No
10	Has documentation been submitted to confirm that the patient is responding to treatment as evident by recent annualized growth velocity that continues to be above their baseline annualized growth velocity value (that is, before the patient started on the requested medication)? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
11	Are the patient's epiphyses open? [If no, no further questions.]	Yes	No
12	Has the patient had limb lengthening surgery in the last 18 months before initiating	Yes	No

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	treatment with the requested medication? [If yes, no further questions.]		
13	Has documentation been submitted demonstrating that the diagnosis of achondroplasia has been confirmed by genetic testing with an identifiable mutation in the fibroblast growth factor receptor type 3 (FGFR3) gene? ACTION REQUIRED: Submit supporting documentation.	Yes	No

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.

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.

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