# PRIOR AUTHORIZATION REQUEST

## SKYCLARYS

**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 this request for initial therapy or for 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**

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| 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 continues to benefit from therapy, as demonstrated by a slowed progression on the modified Friedreich's Ataxia Rating Scale compared to baseline? ACTION REQUIRED: Submit supporting documentation.<br>[No further questions.] | Yes | No |
| 7 | What is the diagnosis or indication?<br><br>[] Friedreich's ataxia (If checked, go to 8)<br><br>[] Metastatic melanoma (If checked, no further questions)<br><br>[] Mitochondrial myopathy (If checked, no further questions)<br><br>[] Other (If checked, no further questions) | | |
| 8 | Is the patient greater than or equal to 16 years of age?<br>[If no, no further questions.] | Yes | No |
| 9 | Has documentation been submitted to confirm that the patient has had genetic testing confirming biallelic pathogenic variants in the frataxin (FXN) gene consistent with a diagnosis of Friedreich's ataxia? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 10 | Is the patient ambulatory?<br>[If no, no further questions.] | Yes | No |
| 11 | Has documentation been submitted to confirm that the patient has a B-type natriuretic peptide (BNP) LESS THAN OR EQUAL TO 200 pg/mL obtained within the last 30 days? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 12 | Has documentation been submitted to confirm that the patient has a left ventricular ejection fraction GREATER THAN OR EQUAL TO 40 percent obtained within the | Yes | No |

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|---|---|---|---|
| | last 30 days? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | | |
| 13 | Has documentation been submitted to confirm that the patient has a hemoglobin A1c (HbA1c) LESS THAN OR EQUAL TO 11 percent obtained within the last 30 days? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 14 | Has documentation been submitted to confirm that the patient has been assessed recently within the last 30 days using the modified Friedreich's Ataxia Rating Scale and has a baseline score GREATER THAN OR EQUAL TO 20, but LESS THAN OR EQUAL TO 80? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 15 | Is the requested medication prescribed by or in consultation with a neurologist or a physician who specializes in ataxias and/or neuromuscular disorders?<br>[If no, no further questions.] | Yes | No |
| 16 | Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication?<br>[Note: Dosing is 150 mg (3 capsules) orally once daily.] | 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.

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