PRIOR AUTHORIZATION REQUEST

VYKAT

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 for the requested medication? [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? [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 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	Is the patient 4 years of age or older with a weight of greater than or equal to 20 kg? [If no, no further questions.]	Yes	No
8	Does the provider attest for females of childbearing potential, use of adequate contraceptive from day 1 until 90 days after last dose of drug? [If no, no further questions.]	Yes	No
9	Does the provider attest for females who are currently breastfeeding, no breastfeeding will occur until 90 days after last dose of drug? [If no, no further questions.]	Yes	No
10	Does the provider attest that the patient does not have clinically significant renal or hepatic impairment? [If no, no further questions.]	Yes	No
11	Has the patient been assessed for hyperglycemia prior to initiating treatment? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
12	Does the provider attest that glucose levels will be monitored throughout treatment? [If no, no further questions.]	Yes	No
13	Does the provider attest that signs and symptoms of fluid overload will be monitored throughout treatment? [If no, no further questions.]	Yes	No
14	What is the indication or diagnosis?		

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[] Hyperphagia associated with Prader-Willi syndrome (PWS) (If checked, go to 15)

[] Other (If checked, no further questions)

15	Has documentation been provided to confirm the diagnosis of Prader-Willi syndrome (PWS) through genetic testing showing at least one of the following: A) Deletion in the chromosomal 15q11-q13 region, B) Maternal uniparental disomy in chromosome 15, or C) Imprinting defects, translocations, or inversions involving chromosome 15? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
16	Does the patient have documented symptoms of hyperphagia (for example, food obsession, aggressive food seeking behavior, lack of satiety)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
17	Is the requested medication prescribed by or in consultation with a genetic specialist, endocrinologist, or pediatrician with substantial clinical experience in the treatment of Prader-Willi syndrome? [If no, no further questions.]	Yes	No
18	Does the provider attest that the requested dose is within the Food and Drug Administration (FDA) labeled dose for the requested indication and will not exceed a max dose of 525 mg?	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

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