OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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Voxzogo®(vosoritide) and Yuviwel®(navepegritide) Prior Authorization Form

***Member Name:*_____ *Date of Birth:*_____ *Member ID#:*_____**

Drug Information

***Pharmacy billing (NDC:*_____) *Start Date (or date of next dose):*_____**

***Drug Name:*_____ *Dose:*_____ *Regimen:*_____**

Pharmacy Information

***Pharmacy NPI*:_____ *Pharmacy Name:*_____**

***Pharmacy Phone:*_____ *Pharmacy Fax:*_____**

Prescriber Information

***Prescriber NPI:*_____ *Prescriber Name:*_____**

***Prescriber Phone:*_____ *Prescriber Fax:*_____ *Specialty:*_____**

Criteria

For Initial Authorization (Initial approval will be for the duration of 6 months):

1. Please indicate the diagnosis and information:

☐ **Achondroplasia**

a. Is diagnosis confirmed by genetic testing identifying a pathogenic mutation in the *FGFR3* gene? Yes☐ No☐

b. Does member have open epiphyses? Yes☐ No☐ Date assessed: _____

c. Is medication prescribed by a geneticist, endocrinologist, or other specialist with expertise in the treatment of achondroplasia (or an advanced care practitioner with a supervising physician who is a geneticist, endocrinologist, or other specialist with expertise in the treatment of achondroplasia)? Yes☐ No☐

d. Member's height: _____(cm); Member's weight: _____(kg); Date taken: _____

e. Member's growth velocity: _____(cm/yr)

f. Has member or caregiver been counseled on proper administration and storage of the medication? Yes☐ No☐

g. For Voxzogo®, has member or caregiver been counseled on the need for adequate food and fluid intake prior to each dose? Yes☐ No☐

h. For Yuviwel®, a patient-specific, clinically significant reason (beyond convenience) why the member cannot use Voxzogo®: _____

☐ **Other:** _____

For Continued Authorization:

1. Member's current height: _____(cm); Member's current weight: _____(kg); Date taken: _____
2. Does member still have open epiphyses? Yes☐ No☐

Additional Information: _____

Prescriber Signature:_____ **Date:**_____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. *Please do not send in chart notes. Specific information will be requested if necessary.*

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.	CONFIDENTIALITY NOTICE *This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*