

**AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM**

**DUR MEDICATION VOXZOGO™ (vosoritide)**

**Fax back to: 1-855-799-2553**

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

**MEMBER INFORMATION**

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Medicaid ID Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Gender:  Male  Female

Weight in Kilograms: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

NPI Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

**DRUG INFORMATION**

Drug Name/Form: \_\_\_\_\_

Strength: \_\_\_\_\_

Dosing Frequency: \_\_\_\_\_

Length of Therapy: \_\_\_\_\_

Quantity per Day: \_\_\_\_\_

*(Form continued on next page.)*

Member's Last Name:

Member's First Name:

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**DIAGNOSIS AND MEDICAL INFORMATION**

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For initial approval, complete the following questions to receive a 12-month approval:

1. Is the member 5 years of age or older? **AND**  
 Yes     No
  
2. Does the member have a definitive diagnosis of achondroplasia as confirmed by one of the following:
  - Clinical (e.g., proximal shortening of arms, large head, narrow chest, short fingers) and radiographic (e.g., ilia and horizontal acetabula, narrow sacrosciatic notch, proximal radiolucency of the femurs, generalized metaphyseal abnormality, decreasing interpedicular distance caudally) features consistent with the disorder; **OR**
  - Identification of a heterozygous pathogenic variant in the *FGFR3* gene (e.g., 1138G>A and 1138G>C being the two most common) by molecular genetic testing? **AND** Yes     No
  
3. Have other causes of achondroplasia or short stature been ruled out (e.g., malnutrition, hypothyroidism, hypocortisolism, hypochondroplasia, thanatophoric dysplasia, SADDAN syndrome, homozygous achondroplasia [excludes approved labeled indication])? **AND**  
 Yes     No
  
4. Does the member have closure of epiphyses? **AND**  
 Yes     No
  
5. Will the member's body weight, growth, and physical development be measured at baseline and monitored throughout therapy? **AND**  
 Yes     No
  
6. Will vosoritide in combination with growth hormones (e.g., somatropin), growth hormone analogs (e.g., somapacitan), or insulin-like growth factors (IGF-1) (e.g., mecasermin) be avoided? **AND**  
 Yes     No
  
7. Does the member have an estimated glomerular filtration rate (eGFR)  $\geq$  60 mL/min/1.73 m<sup>2</sup>? **AND**  
 Yes     No
  
8. Did the member have limb-lengthening surgery within the previous 18 months? **AND**  
 Yes     No
  
9. Is the member going to receive limb-lengthening surgery?  
 Yes     No

*(Form continued on next page.)*

Member's Last Name:

Member's First Name:

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**For renewal, complete the following questions to receive a 12-month approval:**

10. Does the member continue to meet the above criteria? **AND**

Yes     No

11. Does the member have closure of epiphyses? **AND**

Yes     No

12. Has the member had treatment-limiting toxicity (e.g., severe hypotension)? **AND**

Yes     No

13. Has the member shown a beneficial response to treatment as evidenced by the following:

- Improvement in height compared to pre-treatment baseline; **AND**
- Improvement in growth velocity compared to pre-treatment baseline?

Yes     No

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**Prescriber Signature (Required)**

**Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

**Please include ALL requested information; Incomplete forms will delay the PA process.** Submission of documentation does NOT guarantee coverage.