

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.*****PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:**University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit
Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4**CONFIDENTIALITY NOTICE**

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