Voxzogo (vosoritide)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____

AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL**		**IF RENEWAL:** DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Achondroplasia ☐ Other diagnosis: _____ICD-10_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Is this medication being used in conjunction with a clinical trial? ☐ **Yes** ☐ **No**

Have other causes of achondroplasia or short stature have been ruled out (e.g., malnutrition, hypothyroidism, hypocortisolism, hypochondroplasia, thanatophoric dysplasia, SADDAN syndrome, homozygous achondroplasia? ☐ **Yes** ☐ **No** ***Please provide chart note and lab documentation***

Does patient have closure of epiphyses? ☐ **Yes** ☐ **No** ***Please provide chart note documentation***

Will patient's body weight, growth, and physical development will be measured at baseline and monitored throughout therapy? ☐ **Yes** ☐ **No** ***Please provide chart note documentation and dates***

Will Voxzogo be used in combination with growth hormone (i.e., somatropin), or growth hormone analogs (e.g., somapacitan) or insulin-like growth factor (IGF-1) (e.g., mecasermin)? ☐ **Yes** ☐ **No**

Does the patient have an estimated glomerular filtration rate (eGFR) ≥ 60 mL/min? ☐ **Yes** ☐ **No**
Please provide lab documentation

Does the patient have clinical and radiographic features consistent with the disorder OR identification of a heterozygous pathogenic variant in the FGFR3 gene (e.g., 1138G>A and 1138G>C by molecular genetic testing? ☐ **Yes** ☐ **No** ***Please provide chart note and scan documentation***

Has patient had (i.e., within the previous 18 months) or will they receive limb-lengthening surgery? ☐ **Yes** ☐ **No**

For renewal, please answer the following questions:
Is the patient free of unacceptable toxicity from the requested medication? ☐ **Yes** ☐ **No**

Does the patient have closure of epiphyses or decreased growth velocity (< 1.5 cm/year) in the prior 6–12 months? ☐ **Yes** ☐ **No** ***Please provide chart note dates and scan documentation***

Has the patient shown improvement in growth velocity compared to pre-treatment baseline, and improvement in height compared to last measurement that must be within the last 6 months? ☐ **Yes** ☐ **No** ***Please provide chart note dates and documentation***

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ Date: _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811