OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare
Growth Hormone (GH) and Voxzogo® (Vosoritide) Prior Authorization Form

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

Drug Information

Drug Name: _____Strength:_____ NDC: _____

Daily Dose: _____ Fill Date:_____Fill Quantity: _____ Day Supply: _____

Pharmacy Information

Pharmacy NPI:_____ Pharmacy Name:_____

Pharmacy Phone:_____ Pharmacy Fax:_____

Prescriber Information

Prescriber NPI:_____ Prescriber Name:_____

Prescriber Phone:_____ Prescriber Fax:_____ Specialty:_____

Criteria

All information must be provided and SoonerCare may verify through further requested documentation. The member's drug history will be reviewed prior to approval.
Page 1 of 2—Please complete and return <u>all</u> pages. *Failure to complete all pages will result in processing delays*.

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

1. Please indicate the member's diagnosis:

- ☐ Growth hormone deficiency (GHD) of 1 of the following types:
  - ☐ Classic GHD as determined by childhood GH stimulation tests; or
  - ☐ Panhypopituitarism; or
  - ☐ Hypoglycemia with evidence for GHD; or
  - ☐ Neurosecretory dysfunction; or
  - ☐ Other evidence for GHD submitted for panel review and decision; or
- ☐ Short stature associated with Prader-Willi syndrome; or
- ☐ Short stature associated with Noonan syndrome; or
- ☐ Short stature associated with chronic renal insufficiency (pre-transplantation and CrCl <50mL/min); or
- ☐ Growth failure in children born small for gestational age (SGA); or
- ☐ Idiopathic short stature (ISS); or
- ☐ Turner syndrome or 45X, 46XY mosaicism; or
- ☐ Short-stature homeobox-containing gene (SHOX) deficiency with genetic evidence for SHOX deficiency

2. For initial requests, please complete the following information:

A. Date of most recent clinic visit: _____
B. Member's weight (kg): _____Member's height (cm): _____
C. Mother's height (cm) _____ Father's height (cm): _____
D. Does the member have open epiphyses? Yes☐ No☐ Date assessed: _____
E. Growth velocity (cm/yr): _____
F. Bone Age: _____ Yr _____Mo; Chronological Age: _____Yr_____Mo; Date of Scan: _____
G. Have all causes for short stature, other than GH deficiency, been ruled out? Yes☐ No☐
H. Does the member have hypoglycemia? Yes☐ No☐ Glucose: _____mg/dL
   i. If yes, provide additional evidence of GHD: _____
I. Please provide provocative growth hormone stimulation test results:
   Agent: (a) _____ (b) _____ Peak: (a) _____ (b) _____ Date _____

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
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	*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.*

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

2. For initial requests, continued:

J. IGF-1 level & reference range: _____

K. Is the member receiving hormone replacement therapy? Yes ☐ No ☐
If yes, please list: _____

L. Was the member or member's caregiver(s) counseled on proper administration and storage of the requested medication? Yes ☐ No ☐

M. For panhypopituitarism diagnosis:
- i. Does the member have a history of pituitary or hypothalamic injury due to tumor, trauma, surgery, documented whole brain radiation, irradiation, hemorrhage or infarction, or a congenital anomaly? Yes ☐ No ☐
  - a. If yes, does the member lack the hormones testosterone, luteinizing hormone, or follicle-stimulating hormone? Yes ☐ No ☐
  - b. If no, does the member have an MRI showing evidence of pituitary stalk agenesis, empty sella, or ectopic posterior pituitary "bright spot"? Yes ☐ No ☐
- ii. Is the member deficient in ≥3 pituitary hormones? Yes ☐ No ☐
- iii. Is there evidence of tumor recurrence or growth? Yes ☐ No ☐

N. Is member at risk for growth hormone deficiency due to CNS radiation or other organic causes? Yes ☐ No ☐

O. For chronic renal insufficiency diagnosis:
- i. CrCl: _____ mL/min; Is member pre-transplant? Yes ☐ No ☐

P. For small for gestational age (SGA) diagnosis:
- i. Birth weight (kg): _____; Gestational age (weeks): _____
- ii. Is birth weight or length below the 3rd percentile for gestational age? Yes ☐ No ☐

Q. For Prader-Willi syndrome (PWS), Turner syndrome, 45X, 46XY, Noonan syndrome, or SHOX deficiency, was the diagnosis confirmed by a chromosome analysis? Yes ☐ No ☐

R. For SHOX deficiency diagnosis:
- i. Does member have a normal endocrine screen? Yes ☐ No ☐
- ii. Does member have evidence of growth hormone deficiency or insensitivity, tumor activity, diabetes mellitus, history of glucose tolerance, or other serious illness known to interfere with growth? Yes ☐ No ☐

S. Is member transitioning to adult dosing? Yes ☐ No ☐

T. For Voxzogo®:
- i. Does the member have achondroplasia confirmed by genetic testing identifying a pathogenic mutation in the *FGFR3* gene? Yes ☐ No ☐
- ii. Was the 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 ☐
- iii. Was the member or member's caregiver(s) counseled on proper administration and storage, including the need for adequate food and fluid intake with Voxzogo®? Yes ☐ No ☐

3. For continued approval, please complete the following information:

A. Date of most recent clinic visit: _____

B. Member's weight (kg): _____ Member's height (cm): _____

C. Open epiphyses? Yes ☐ No ☐ Date assessed: _____

D. Growth velocity (cm/yr): _____

E. For members on adult growth hormone dosing, please provide:
- i. IGF-1 level: _____; Reference range: _____
- ii. IGF-1 standard deviation score (SDS): _____; Date measured: _____

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. *Failure to complete this form in full will result in processing delays.*

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Pharmacy Management Consultants
Product Based Prior Authorization Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

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