Prior Authorization Form

Note: Please provide as much information as possible on this form. Missing data may cause processing delays for requested authorization(s). Attach additional sheets to this form if necessary.

Please fax the completed PA form and any additional informational sheets to Nirvanahealth at the following fax number: +1(866) 871-8565

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
Health Plan Name:		Prescriber Address:	
Patient Insurance Id:			
Patient Date of Birth:		Prescriber Phone:	( )
Patient Phone:		Prescriber Fax:	( )
		Prescriber Specialty:	
		Prescriber DEA:	
		Prescriber NPI:	

Medication & Medical Information	
Requested Drug(s) & Strength(s):	[ ] Voxzogo 0.4 mg subcutaneous solution [ ] Voxzogo 0.56 mg subcutaneous solution [ ] Voxzogo 1.2 mg subcutaneous solution
Requested Daily Quantity Limit – Amount:	
Requested Daily Quantity Limit – Days:	
Expected Length of Therapy:	
Directions:	
Diagnosis and Diagnosis Codes (ICD-10 Standard Codes):	
List drugs used previously to treat the same condition:	
Additional clinical information or history. Please include any relevant test results and/or medical record notes:	

Questionnaire

Q1: I, as the provider or designated representative of the provider, certify and attest that the information provided is complete and accurate and that, upon request, I shall provide any information to RxAdvance that RxAdvance determines is reasonably necessary to verify my responses. (Check only one that apply)

[ ] Yes

[ ] No

Q2: Is the member currently treated with this medication? (Check only one that apply)

[ ] Yes (please list start date of therapy (month/day/year)) _____ (*Required)

[ ] No

Q3: What is the member's diagnosis? (Check only one that apply)

[ ] Open epiphyses

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request)
_____(*Required)

Q4: Does the member have documentation of a positive clinical response to therapy as evidenced by one of the following: (Check only one that apply)

[ ] Improvement in annualized growth velocity (AGV) compared to baseline (please provide the supporting documents)
_____(*Required)

[ ] Improvement in height Z-score compared to baseline (please provide the supporting documents)
_____(*Required)

[ ] No (please provide medical justification for continuation of therapy)
_____(*Required)

Q5: What is the member's diagnosis? (Check only one that apply)

[ ] Open epiphyses

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request)
_____(*Required)

Q6: Does the member have achondroplasia as confirmed by clinical manifestations characteristic of achondroplasia (e.g., macrocephaly, frontal bossing, midface retrusion, disproportionate short stature with rhizomelic shortening of the arms and the legs, brachydactyly, trident configuration of the hands, thoracolumbar kyphosis, and accentuated lumbar lordosis)? (Check only one that apply)

[ ] Yes (please provide the supporting documents) _____
(*Required)

[ ] No

Q7: Does the member have radiographic findings characteristic of achondroplasia (e.g., large calvaria and narrowing of the foramen magnum region, undertubulated, shortened long bones with metaphyseal abnormalities, narrowing of the interpedicular distance of the caudal spine, square ilia and horizontal acetabula, small sacrosciatic notches, proximal scooping of the femoral metaphyses, and short and narrow chest)? (Check only one that apply)

[ ] Yes (please provide the supporting documents) _____
(*Required)

[ ] No

Q8: Is the molecular genetic testing confirmed c.1138G to A or c.1138G to C variant (i.e., p.Gly380Arg mutation) in the fibroblast growth factor receptor-3 (FGFR3) gene? (Check only one that apply)

[ ] Yes (please provide the supporting documents) _____
(*Required)

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Q9: Did the member have limb-lengthening surgery in the previous 18 months? (Check only one that apply)

[ ] Yes (please specify date(s) of surgery (month/year)) _____
(*Required)

[ ] No

Q10: Does the member have plan on having limb-lengthening surgery while on Voxzogo therapy? (Check only one that apply)

[ ] Yes

[ ] No

Q11: Is the member at least 5 years old? (Check only one that apply)

[ ] Yes

[ ] No (please provide member's age and clinical rationale for the request)
_____(*Required)

Q12: Is the reqeusted medication prescribed by or in consultation with a a clinical geneticist, endocrinologist, or a physician who has specialized expertise in the management of achondroplasia? (Check only one that apply)

[ ] Yes (please specify prescriber specialty) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____
(*Required)

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 designated representatives may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.	
Signature of Prescriber or Authorized Representative:	Date:
Print Authorized Representative Name:	