Prior Authorization Request Form for lonapegsomatropin-tcgd injection (Skytrofa)

6714

To be completed and signed by the prescriber.

MARTIN'S POINT® HEALTHCARE

Please fax completed form back to: (207) 828-7816

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization expires after 1 year.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. The provider acknowledges that Norditropin is the Department of Defense's preferred somatropin agent.	☐ Acknowledged Proceed to question **2**	
2. Is the patient greater than or equal to 1 year of age?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Does the patient weigh at least 11.5 kg?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the requested medication being used for the indication of growth failure due to an inadequate secretion of endogenous growth hormone (GH) in pediatric patients? Note: Non-FDA-approved uses are not approved, including Idiopathic Short Stature, normal aging process, obesity, and depression.	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Is the requested medication prescribed by or in consultation with a pediatric endocrinologist or nephrologist who recommends therapeutic intervention and will manage treatment?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Does the patient have a contraindication to Norditropin? Note: all possible preservative formulations are available between Norditropin, Omnitrope and Zomacton Note: patient preference for a particular device is insufficient grounds for approval of an NF agent.	☐ Yes Proceed to question **8**	☐ No Proceed to question **7**

Prior Authorization Request Form for lonapegsomatropin-tcgd injection (Skytrofa)

7. **Has the patient experienced an adverse reaction(s) to Norditropin, Omnitrope, AND Zomacton that is not expected to occur with Skytrofa?** Note: all possible preservative formulations are available between Norditropin, Omnitrope and Zomacton Note: patient preference for a particular device is insufficient grounds for approval of an NF agent.	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. **Does the patient require a less than daily dosing regimen due to needle intolerance or aversion?**	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. **Will the requested medication be used concomitantly with multiple somatropin agents?**	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3

I certify the above is true to the best of my knowledge.
Please sign and date:

Prescriber Signature _____ Date _____

[11 May 2022]