



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: [HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI DISCLOSURE AUTHORIZATION.PDF](https://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF)

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:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> 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*





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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:** _____

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program

Attn: CP – 4201

P.O. Box 64811

St. Paul, MN 55164-0811

