Skytrofa (lonapegsomatropin-tcgd)
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

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** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

Continued on next page.

Skytrofa (lonapegsomatropin-tcgd)
Prior Authorization Request Form

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

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:**
☐ Growth Hormone Deficiency (GHD) ☐ Other diagnosis: _____ICD-10_____	

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

Is this drug being used as part of a clinical trial? ☐ Yes ☐ No

Does patient have growth failure secondary to Growth Hormone Deficiency? ☐ Yes ☐ No *Chart note documentation required*

Have other causes of growth failure been ruled out? ☐ Yes ☐ No *Chart note documentation required*

Does patient have a current acute critical illness after open heart surgery, abdominal surgery or multiple accidental trauma, or those with acute respiratory failure? ☐ Yes ☐ No

Does patient have active malignancy. ☐ Yes ☐ No *Chart note documentation required*

Is the patient free of closed epiphyses (pediatric patient's only)? ☐ Yes ☐ No *Chart note documentation required*

Does the patient have short stature as defined by height that is 2 SD or more below the mean for chronological age? ☐ Yes ☐ No *Please provide documentation*

Does the patient have hypothalamic-pituitary defects (i.e. major congenital malformation, tumor, or irradiation) and a deficiency of at least one additional pituitary hormone? ☐ Yes ☐ No *Please provide documentation*

Has the patient had an inadequate response to GH provocation tests on 2 separate stimulation tests as defined as a serum peak GH concentration < 10 ng/ml? ☐ Yes ☐ No *Please provide documentation and dates*

Does the patient have Prader-Willi syndrome with any of these risk factors? (severe obesity, history of upper airway obstruction or sleep apnea or have severe respiratory impairment, or unidentified respiratory infection) ☐ Yes ☐ No

Does the patient have idiopathic short stature? ☐ Yes ☐ No

Has the patient trialed and had an intolerance to Norditropin (somatotropin)? ☐ Yes ☐ No
Please provide detailed rationale of why treatment cannot be continued (such as allergic rash or difficulty breathing)

If patient has had an intolerance to Norditropin has the U.S. FDA MedWatch Voluntary Reporting Form for adverse drug reactions (FDA Form 3500) been filed with the FDA? □ Yes □ No ***Please provide chart note documentation of MedWatch form***

Does patient have an absolute contraindication to trial of Norditropin (such as a documented patient allergy to a known dye or binder or additive in the product)? □ Yes □ No ***Please provide documentation***

For renewal, please answer the following:
Has patient shown beneficial response compared to pretreatment baseline (with lonapegsomatropin or somatropin [if used as switch maintenance]) evidenced by one or more of the following: Improvement in height or growth velocity?
□ Yes □ No ***Please provide documentation***

Is the patient free of growth velocity failure due to advanced bone age and/or antibodies to recombinant human growth hormone?
□ Yes □ No ***Please provide 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: Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.
4801 E. Washington Street, Phoenix, AZ 85034
Phone: 877-228-7909