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



USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to:

(410) 424-4037

To be completed by Requesting provider				
Drug Name:	Strength:			
Dosage/Frequency (SIG):	Duration of Therapy:			

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

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

Please complete patient and physician information (please print): Patient Name:	Prior aut	thorizatio	on expires after	· 1 year.							
Address: Sponsor ID # Date of Birth: Secure Fax #:		Please complete patient and physician information (please print):									
Sponsor ID #		Patient Name: Ph			ysician Name:						
Date of Birth: Secure Fax #: Step Please complete the clinical assessment:		Sponsor ID # Date of Birth:			Address:						
Date of Birth: Secure Fax #: Step Please complete the clinical assessment:						_					
Please complete the clinical assessment: 1. The provider acknowledges that Norditropin is the Department of Defense's preferred somatropin agent.					Secure Fax #:						
1. The provider acknowledges that Norditropin is the Department of Defense's preferred somatropin agent. 2. Is the patient greater than or equal to 1 year of age? 2. Is the patient weigh at least 11.5 kg? 3. Does the patient weigh at least 11.5 kg? 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. 5. Is the requested medication prescribed by or in consultation with a pediatric endocrinologist or nephrologist who recommends therapeutic 1. The provider acknowledged Proceed to question 2 2. Acknowledged Proceed to question 3 STOP Coverage not approved 1. Yes Proceed to question 4 STOP Coverage not approved 1. Yes Proceed to question 5 STOP Coverage not approved 1. Stop Proceed to question 5 STOP Coverage not approved 1. Stop Proceed to question 6 STOP											
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	6.	Does the patient have a contraindication to Norditropin?	□ Yes	□ No	
		Note: all possible preservative formulations are available between Norditropin, Omnitrope and Zomacton	Proceed to question 8	Proceed to question 7	
		Note: patient preference for a particular device is insufficient grounds for approval of an NF agent.			
	7.	Has the patient experienced an adverse reaction(s) to Norditropin, Omnitrope, AND Zomacton that is not expected to occur with Skytrofa?	☐ Yes Proceed to question 8	□ No STOP	
		Note: all possible preservative formulations are available between Norditropin, Omnitrope and Zomacton		Coverage not approved	
		Note: patient preference for a particular device is insufficient grounds for approval of an NF agent.			
	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		fy the above is true to the best of my knowledge sign and date:	ge.		
		Prescriber Signature	Date		
				[11 May 2022]	
For Inter	nal Use	Only			
Appro	Approved:		Duration of Approval:	month(s)	
Denie	d:		Authorized By:		
☐ Incom	plete/Oth	ner:	PA#:		
Date Fax	ed to MD):	Date Decision Rendered:		