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

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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

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.

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**

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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**
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]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: