



2/20/2026

Prior Authorization

Internal Use Only

JOHNS HOPKINS HEALTH PLANS

Vykat - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.  
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**.  
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.

When conditions are met, we will authorize the coverage of Vykat - Priority Partners MCO.

Drug Name (select from list of drugs shown)

Vykat XR (diazoxide choline)

Quantity

Frequency

Strength

Route of Administration

Expected Length of Therapy

Patient Information

Patient Name: \_\_\_\_\_

Patient ID: \_\_\_\_\_

Patient Group No.: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Patient Phone: \_\_\_\_\_

Prescribing Physician

Physician Name: \_\_\_\_\_

Physician Phone: \_\_\_\_\_

Physician Fax: \_\_\_\_\_

Physician Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

ICD Code: \_\_\_\_\_

Comments: \_\_\_\_\_

Please circle the appropriate answer for each question.

1. Is the requested medication being prescribed for any indications or uses that are not Food and Drug Administration (FDA)-approved, or guideline-supported?

Y  N

[If yes, no further questions.]

2. Will the requested medication be used for the treatment of hyperinsulinemic hypoglycemia?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
3. Does the patient have renal or hepatic impairment?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
4. Does the patient have known hypersensitivity to diazoxide or thiazides?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
5. Is the patient less than 4 years of age?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
6. Has the plan authorized the requested medication in the past for this patient (i.e., previous authorization is on file under this plan)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.	
[If no, skip to question 9.]	
7. Does the patient have documentation showing a positive response to treatment, evidenced by a decrease in food-related behaviors, or lessened of food preoccupation?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
8. Does the patient have ongoing laboratory results showing the hemoglobin A1c (HbA1c) is being monitored every 3 months and as clinically indicated?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[No further questions.]	
9. Does the patient have a diagnosis of Prader-Willi syndrome (PWS)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
10. Is there a genetic test confirmation of a mutation in chromosome 15?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
11. Does the patient have hyperphagia, evidenced by food obsession, aggressive food seeking, and a lack of satiety?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
12. Has the patient's baseline fasting plasma glucose and hemoglobin A1c (HbA1c) been measured?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	

13. Does the patient have presence of hyperglycemia?	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
NOTE: Submission of medical records is required.		
[If no, skip to question 15.]		
14. Has the patient's blood glucose been optimized?	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
15. Does the patient have established nutritional goals with the consultation of a dietitian or nutritionist?	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
16. Have behavioral and environmental modifications been implemented, and will be continued to maintain a food secure environment (for example, locked food storage)?	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
NOTE: Submission of medical records is required.		

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

<b>Prescriber (Or Authorized) Signature and Date</b>