

Prior Authorization Request Form for
triheptanoin oral liquid (**Dojolvi**)



JOHNS HOPKINS
HEALTHCARE

7231 Parkway Drive, Suite 100, Hanover, MD 21076

**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.

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:

<p>1. For which indication or diagnosis is the requested medication being prescribed?</p> <p>Note: Non-FDA-approved uses are NOT approved including use for weight loss in a ketogenic diet.</p>	<input type="checkbox"/> (Molecularly confirmed) Long-chain fatty acid oxidation disorder (LC-FAOD) - Proceed to Question 2 <input type="checkbox"/> Other - STOP Coverage not approved	
<p>2. Is the requested medication prescribed by or in consultation with a geneticist, neurologist, or LC-FAOD expert?</p>	<input type="checkbox"/> Yes Proceed to Question 3	<input type="checkbox"/> No STOP Coverage not approved
<p>3. Is the patient experiencing symptoms of deficiency exhibited by the presence of at least 1 of the following:</p> <ul style="list-style-type: none"> • severe neonatal hypoglycemia • hepatomegaly • cardiomyopathy • exercise intolerance • frequent episodes of myalgia • recurrent rhabdomyolysis induced by exercise • fasting or illness • associated decreased quality of life? 	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

_____	_____
Prescriber Signature	Date

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For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____ month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: