TRICARE Prior Authorization Request Form for
elamipretide hcl (Forzinity)



JOHNS HOPKINS
HEALTH PLANS

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.

Prior authorization expires in 6 months. Provider must fill out a new prior authorization.

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. Is the requested medication being prescribed by a physician with expertise in mitochondrial medicine or genetic disorders?	☐Yes Proceed to question **2**	☐No **STOP** **Coverage not approved**
2. Is the patient 12 years of age or older?	☐Yes Proceed to question **3**	☐No **STOP** **Coverage not approved**
3. What is the indication or diagnosis?	☐Genetically confirmed Barth syndrome (BTHS) - Proceed to question **4** ☐Other diagnosis **– STOP – Coverage not approved**	
4. Does the patient weigh AT LEAST 30 kg?	☐Yes Proceed to question **5**	☐No **STOP** **Coverage not approved**
5. Is the patient ambulatory yet impaired as assessed by the 6-minute walk test (6MWT)?	☐Yes Proceed to question **6**	☐No **STOP** **Coverage not approved**
6. Does the patient have any of the following: undergoing a pubertal growth spurt, uncontrolled hypertension, history of heart transplant, implantation of cardiac defibrillator, receiving chemotherapeutic or immunosuppressant agents, or prior radiation therapy to the chest?	☐Yes **STOP** **Coverage not approved**	☐No Proceed to question **7**

7. Provider acknowledges accelerated approval is based on improvement in knee extensor muscle strength and continued FDA approval may be contingent upon verification of clinical benefit in confirmatory trials.	☐ **Acknowledged** **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

[15 July 2026]

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