TRICARE Prior Authorization Request Form for
vosoritide **(Voxzogo)**

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HEALTH PLANS
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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 clinical assessment:

1. Does the patient have a documented diagnosis of achondroplasia with open epiphyses?	☐ Yes proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the requested medication prescribed by or in consultation with a pediatric endocrinologist?	☐ Yes proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Does the provider acknowledge that Voxzogo was FDA approved in accelerated fashion and continued approval may be contingent upon verification and description of clinical benefit in confirmatory trials?	☐ Yes proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Does the provider acknowledge that a clinical benefit with Voxzogo has not been proven?	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Has the patient/caregiver been instructed on how to properly use, store, and administer Voxzogo?	☐ Yes proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Does the provider agree to monitor growth and adjust dose according to body weight?	☐ Yes proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Does the provider agree to permanently discontinue Voxzogo upon closure of epiphyses?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

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

Prescriber Signature _____ Date _____

[26 June 2024]

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