SENTARA HEALTH PLANS

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Hyftor® (sirolimus topical gel)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Recommended Dosing: Topical: Apply twice daily (in the morning and at bedtime) to the affected facial skin; the maximum recommended daily dose is 800 mg (2.5 cm). If symptoms do not improve within 12 weeks, re-evaluate the need for continuing therapy

Quantity Limit: 3 tubes per 30 days

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 6 months

- ❑ Member is ≥ 6 years of age
- ❑ Medication is prescribed by or in consultation with a dermatologist or a physician who specializes in the management of patients with tuberous sclerosis complex

(Continued on next page)

- ❑ Member has a definitive diagnosis of tuberous sclerosis complex as confirmed by **ONE** of the following:
  - ❑ There is identification of a pathogenic variant in the tuberous sclerosis complex 1 (TSC1) gene or tuberous sclerosis complex 2 (TSC2) gene by genetic testing
  - ❑ According to the prescriber, clinical diagnostic criteria suggest a definitive diagnosis of tuberous sclerosis complex by meeting either two major features or one major feature with two minor features [**NOTE:** Major feature criteria involve angiofibroma (three or more) or fibrous cephalic plaque; angiomyolipomas (two or more); cardiac rhabdomyoma; hypomelanotic macules (three or more; at least 5 mm in diameter); lymphangiomyomatosis; multiple cortical tubers and/or radial migration lines; multiple retinal hamartomas; Shagreen patch; subependymal giant cell astrocytoma; subependymal nodule (two or more); or ungula fibromas (two or more). Minor feature criteria involve "confetti" skin lesions; dental enamel pits (three or more); intraoral fibromas (two or more); multiple renal cysts; nonrenal hamartomas; retinal achromic patch; and sclerotic bone lesions]
- ❑ Member has three or more facial angiofibromas that are at least 2 mm in diameter with redness in each

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member has experienced a positive clinical response to Hyftor as evidenced by a reduction in the size and/or redness of the facial angiofibromas, as determined by the prescriber
- ❑ Member has experienced an absence of unacceptable toxicity from the drug (e.g., dermal irritation, high-grade photosensitivity)

Medication being provided by Specialty Pharmacy – Proprium Rx

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****