

# 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:** Forzinity™ (elamipretide)

**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 Dosage:** SUBQ: 40 mg once daily

**Quantity Limits:** 4 vials (14 mL) per 28 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 12 years of age or older
- Member weighs 30 kg or greater
- Prescriber is a geneticist, cardiologist, metabolic specialist, hematologist, pediatrician, or a physician who specializes in the treatment of mitochondrial disorder

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- Member meets **ONE** of the following:
  - Member is an adult and meets **ONE** of the following (**submit documentation**):
    - Member has estimated glomerular filtration rate (eGFR) greater than or equal to 30 mL/min
    - Member has an eGFR less than 30 mL/min and is **NOT** on dialysis
  - Member is a pediatric patient and is **NOT** renally impaired
- Member's diagnosis of Barth syndrome was confirmed by at least **ONE** of the following (**submit documentation**):
  - Genetic testing documenting a pathogenic variant in the TFAZZIN gene [**NOTE: Gene testing must demonstrate a hemizygous pathogenic variant in the TFAZZIN (TAZ) gene**]
  - Increased monolysocardioliipin: cardioliipin (MLCL/CL) ratio
- Provider must submit documentation to confirm member is ambulatory (i.e., able to complete a 6-minute walk test)
- Provider must submit documentation to confirm the member has functional impairment related to muscle strength (e.g., knee extensor muscle strength measured by handheld dynamometry)
- Member has **NOT** previously undergone and is **NOT** planned to undergo heart transplantation

**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 continues to meet all initial authorization criteria
- Member is responding positively to therapy as evidenced by improvement in muscle strength (e.g. knee extensor muscle strength measured by handheld dynamometry) (**submit documentation**)

**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.\****