SENTARA COMMUNITY PLAN
(MEDICAID)

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: select one drug below

❑ **Voxzogo®** (vosoritide)	❑ **Yuviwel®** (navepegritide)

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:** _____

Requested Medication is ONE of the following:

- ❑ New Start
- ❑ Continuation of therapy

(Continued on next page)

A. Voxzogo:

- **Quantity Limit:** Maximum approval of 1 vial per day and maximum dose of 1.2 mg daily
- **Recommended Dosage:** Weight-based dosing will be approved based on dosing guidelines as follows:

Actual Body Weight	Vial Strength for Reconstitution*	Dose	Injection Volume
10-11 kg	0.4 mg	0.24 mg	0.3 mL
12-16 kg	0.56 mg	0.28 mg	0.35 mL
17-21 kg	0.56 mg	0.32 mg	0.4 mL
22-32 kg	0.56 mg	0.4 mg	0.5 mL
33-43 kg	1.2 mg	0.5 mg	0.25 mL
44-59 kg	1.2 mg	0.6 mg	0.3 mL
60-89 kg	1.2 mg	0.7 mg	0.35 mL
≥ 90 kg	1.2 mg	0.8 mg	0.4 mL

B. Yuviwel:

- **Quantity Limit:** Maximum approval of 4 kits per month for 1.3 mg and 2.8 mg strengths & 8 kits per month for 5.5 mg strength
- **Recommended Dosage:** Weight-based dosing will be approved based on dosing guidelines as follows:

Actual Body Weight	Weekly dose	Dose Volume	Vial strength needed for reconstitution	Reconstituted concentration
8 to <10 kg	0.88 mg once weekly	0.4 mL	1.3 mg/vial	2.2 mg/mL
10 to <13.5 kg	1.2 mg once weekly	0.55 mL		
13.5 to <17.6 kg	1.6 mg once weekly	0.35 mL	2.8 mg/vial	4.6 mg/mL
17.6 to <23.1 kg	2.1 mg once weekly	0.45 mL		
23.1 to <30.6 kg	2.8 mg once weekly	0.6 mL		
30.6 to <41.3 kg	3.6 mg once weekly	0.65 mL	5.5 mg/vial	5.5 mg/mL
41.3 to <56 kg	5 mg once weekly	0.9 mL		
56 to <73.6 kg	6.6 mg once weekly	1.2 mL (use 2 kits)		
73.6 to 90 kg	8.8 mg once weekly	1.6 mL (use 2 kits)		

(Continued on next page)

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: 12 months

- ❑ Medication must be prescribed by or in consultation with a specialist in the area of the member's diagnosis (e.g., endocrinologist, geneticist)
- ❑ For Yuviwel ONLY: Member is 2 years of age or older
- ❑ Member has a definitive diagnosis of achondroplasia as confirmed by one of the following:
  - ❑ Clinical (e.g., proximal shortening of arms, large head, narrow chest, short fingers) and radiographic (e.g., square ilia and horizontal acetabula, narrow sacrosciatic notch, proximal radiolucency of the femurs, generalized metaphyseal abnormality, decreasing interpedicular distance caudally) features consistent with achondroplasia
  - ❑ Identification of a heterozygous pathogenic variant in the fibroblast growth factor receptor 3 (FGFR3) gene by molecular genetic testing
- ❑ Member has open epiphyses
- ❑ Member's baseline annualized growth velocity will be measured (prior to treatment with the requested agent)
- ❑ Requested medication will **NOT** be used in combination with therapy involving other C-type natriuretic peptide (CNP) analogs or growth hormone agents
- ❑ Member's estimated glomerular filtration rate (eGFR) is ≥ 60 mL/min/1.73m^2
- ❑ Member has not received limb-lengthening surgery (within the previous 18 months)
- ❑ Member will **NOT** receive limb-lengthening surgery

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 continues to experience clinical benefit from the requested treatment

Medication being provided by Specialty Pharmacy – PropriumRx

*****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.****

***Approved by Pharmacy and Therapeutics Committee:** ~~3/17/2022;~~ **5/28/2026**
REVISED/REFORMATTED/UPDATED: ~~3/10/2022; 5/9/2022; 6/15/2022; 6/16/2022; 10/27/2023, 2/9/2024; 6/15/2026;~~ **10/16/2026**