PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 6/13/2025
Patient ID: _____ **Patient Date Of Birth:**
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
_____ **NPI#:** **Specialty:**
Physician Office Address: _____ **Physician Office Telephone:**
_
Drug Name (specify drug) _____
Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____
Comments: _____
_____
_____

Please check the appropriate answer for each applicable question.

1. What is the diagnosis?
   - Achondroplasia (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐
   _____

2. Is Voxzogo being prescribed by or in consultation with an endocrinologist, pediatric endocrinologist, geneticist, or neurologist? **Y** ☐ **N** ☐

3. Is the diagnosis of achondroplasia confirmed by symptoms (i.e., short stature with marked shortening of extremities due to rhizomelia, a characteristic facial configuration, trident hand) AND X-ray findings consistent with achondroplasia? ACTION REQUIRED: If Yes, please attach chart notes or documentation of symptoms and laboratory report of X-ray findings AND most recent growth chart. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

4. Was the diagnosis of achondroplasia confirmed by genetic testing for the FGFR3 mutation? ACTION REQUIRED: If Yes, please attach laboratory report of genetic testing AND most recent growth chart. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

5. Are the epiphyses open? **Y** ☐ **N** ☐

6. Is the patient currently receiving Voxzogo? **Y** ☐ **N** ☐

7. Has the patient experienced benefit from therapy (e.g., improvement or stabilization of annualized growth velocity [centimeters per year] from baseline)? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation confirming benefit from therapy. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date