# Voxzogo

## Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

**Patient's Name:** _____**Date**: _____
**Patient's ID:** _____ **Patient's Date of Birth:** _____
**Physician's Name:** _____
**Specialty:** _____ **NPI#:** _____
**Physician Office Telephone:** _____ **Physician Office Fax:** _____
**Request Initiated For:** _____

1. What is the patient's diagnosis?
   ❑ Achondroplasia ❑ Other_____
2. What is the ICD-10 code? _____
3. Is the patient currently receiving Voxzogo? ❑ Yes ❑ No
4. Are there chart notes or documentation of 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 X-ray findings and skip to #6.*** ❑ Yes ❑ No
5. Was the diagnosis of achondroplasia confirmed by genetic testing for the FGFR3 mutation? ***ACTION REQUIRED: If Yes, please attach genetic testing demonstrating FGFR3 mutation.*** ❑ Yes ❑ No
6. Please indicate the annualized growth velocity (centimeters per year) at baseline. _____ cm
   ***ACTION REQUIRED: If Yes, please attach growth chart showing with the annualized growth velocity.***
7. Has the patient achieved improvement or stabilization of annualized growth velocity (centimeters per year) from baseline? ***ACTION REQUIRED: If Yes, please attach growth chart showing improvement or stabilization of annualized growth velocity.*** ❑ Yes ❑ No
8. Does the patient have open epiphyses? ❑ Yes ❑ No
9. Is Voxzogo being prescribed by or in consultation with an endocrinologist, pediatric endocrinologist, geneticist, or neurologist? ❑ Yes ❑ No

***I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.***

**X**_____
Prescriber or Authorized Signature Date (mm/dd/yy)

**Send completed form to: Case Review Unit CVS Caremark Prior Authorization Fax: 1-866-249-6155**