

# US Family Health Plan

## Prior Authorization Request Form for lonapegsomatropin-tcgd injection (**Skytrofa**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:  
**Attn: Pharmacy, 77 Warren St, Brighton, MA 02135**

**QUESTIONS? Call 1-877-880-7007**

Prior authorization expires after 1 year.

**Step 1** Please complete patient and physician information (please print):

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID #: _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

**Step 2** Please complete the clinical assessment:

<p><b>1. The provider acknowledges that Norditropin is the Department of Defense's preferred somatropin agent.</b></p>	<input type="checkbox"/> Acknowledged Proceed to question <b>2</b>	
<p><b>2. Is the patient greater than or equal to 1 year of age?</b></p>	<input type="checkbox"/> Yes Proceed to question <b>3</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<p><b>3. Does the patient weigh at least 11.5 kg?</b></p>	<input type="checkbox"/> Yes Proceed to question <b>4</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<p><b>4. Is the requested medication being used for the indication of growth failure due to an inadequate secretion of endogenous growth hormone (GH) in pediatric patients?</b></p> <p style="font-size: small;">Note: Non-FDA-approved uses are not approved, including Idiopathic Short Stature, normal aging process, obesity, and depression.</p>	<input type="checkbox"/> Yes Proceed to question <b>5</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<p><b>5. Is the requested medication prescribed by or in consultation with a pediatric endocrinologist or nephrologist who recommends therapeutic intervention and will manage treatment?</b></p>	<input type="checkbox"/> Yes Proceed to question <b>6</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<p><b>6. Does the patient have a contraindication to Norditropin?</b></p> <p style="font-size: small;">Note: all possible preservative formulations are available between Norditropin, Omnitrope and Zomacton</p> <p style="font-size: small;">Note: patient preference for a particular device is insufficient grounds for approval of an NF agent.</p>	<input type="checkbox"/> Yes Proceed to question <b>8</b>	<input type="checkbox"/> No Proceed to question <b>7</b>

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<p><b>7. Has the patient experienced an adverse reaction(s) to Norditropin, Omnitrope, AND Zomacton that is not expected to occur with Skytrofa?</b></p> <p>Note: all possible preservative formulations are available between Norditropin, Omnitrope and Zomacton</p> <p>Note: patient preference for a particular device is insufficient grounds for approval of an NF agent.</p>	<p><input type="checkbox"/> Yes Proceed to question <b>8</b></p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p><b>8. Does the patient require a less than daily dosing regimen due to needle intolerance or aversion?</b></p>	<p><input type="checkbox"/> Yes Proceed to question <b>9</b></p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p><b>9. Will the requested medication be used concomitantly with multiple somatropin agents?</b></p>	<p><input type="checkbox"/> Yes <b>STOP</b> Coverage not approved</p>	<p><input type="checkbox"/> No <b>Sign and date below</b></p>

**Step 3** I certify the above is true to the best of my knowledge.  
Please sign and date:

\_\_\_\_\_ Prescriber Signature

\_\_\_\_\_ Date