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:**

1. The provider acknowledges that Norditropin is the Department of Defense's preferred somatropin agent.	☐ Acknowledged Proceed to question **2**	
2. Is the patient greater than or equal to 1 year of age?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Does the patient weigh at least 11.5 kg?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
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? Note: Non-FDA-approved uses are not approved, including Idiopathic Short Stature, normal aging process, obesity, and depression.	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Is the requested medication prescribed by or in consultation with a pediatric endocrinologist or nephrologist who recommends therapeutic intervention and will manage treatment?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Does the patient have a contraindication to Norditropin? Note: all possible preservative formulations are available between Norditropin, Omnitrope and Zomacton Note: patient preference for a particular device is insufficient grounds for approval of an NF agent.	☐ Yes Proceed to question **8**	☐ No Proceed to question **7**

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

Step 3

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

Prescriber Signature _____ Date _____

[11 May 2022]