IOWA Health and Human Services

Request for Prior Authorization
Diazoxide Choline (Vykat XR)

FAX Completed Form To
1 (800) 574-2515
Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone

Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.

Pharmacy NPI	Pharmacy fax	NDC

Prior authorization (PA) is required for diazoxide choline (Vykat XR). Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and

2. Patient has a diagnosis of Prader-Willi syndrome confirmed by genetic testing (attach results); and

3. Patient has hyperphagia with associated symptoms such as food-seeking behaviors (hoarding, foraging, stealing, and attempting to consume inedible items); and

4. Patient's current weight in kg is provided; and

5. Is prescribed by or in consultation with an endocrinologist.

If the criteria for coverage is met, initial requests will be approved for 6 months. Additional approvals will be considered under the following conditions:

1. **Documentation showing improvement or stabilized symptoms of disease such as decrease in food related behaviors, lessened food preoccupation that affects daily life, etc.; and**
2. **Patient's current weight in kg is provided.**

Non-Preferred

☐ Vykat XR

Strength	Usage Instructions	Quantity	Day's Supply
_____	_____	_____	_____

Diagnosis (attach genetic testing results): _____

Does patient have hyperphagia with associated symptoms?

- ❑ Yes Describe associated symptoms: _____
- ❑ No

Patient's current weight in kg: _____ **Date obtained:** _____

Is prescriber an endocrinologist?

❑ Yes, document specialty: _____

❑ No (If no, note consultation with specialist):

Consultation Date:_____Physician Name, Specialty & Phone: _____

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Renewal Requests

Document improvement or stabilized signs and symptoms of disease: _____

_____

_____

Patient's current weight in kg: _____ Date obtained: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization, the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary, by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*