Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Skyclarys (omaveloxolone) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 3 months; Continuation- 6 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Skyclarys (omaveloxolone).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours (fax: 1-866-331-2104). If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

An Interregional Consultative Physician Panel review is recommended prior to initiating treatment

1. Prescriber is a Neurologist, Pediatric Neurologist, or Medical Geneticist,
   □ No □ Yes
2. **AND** patient is ≥16 years and ≤40 years of age,
   □ No □ Yes
3. **AND** diagnosis of Friedreich's ataxia with confirmatory genetic testing,
   □ No □ Yes
4. **AND** modified Friedreich's Ataxia Rating Scale (mFARS) score ≥20 and ≤80,
   □ No □ Yes
5. **AND** left ventricular ejection fraction (LVEF) ≥40%,
   □ No □ Yes
6. **AND** patient is using effective contraception, if patient is of childbearing potential
   □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below:

1. Documentation of positive clinical response,
   □ No □ Yes
2. **AND** specialist follow-up occurred since last review,
   □ No □ Yes
3. **AND** documentation of completing the following labs:
   a. SCr, if patient has clinically significant renal disease
   b. Liver function tests (ALT, AST, bilirubin), BNP, and lipids
   □ No □ Yes
4. **AND** patient does not have any of the following:
   a. Increase in transaminase levels >5X ULN or >3X ULN with evidence of liver dysfunction
   b. Becomes wheelchair bound or non-ambulatory
   c. Intolerance to medication
   d. Documented non-adherence to medication
   e. Pregnancy or breastfeeding
   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**