Jefferson Health Plans

MEDICAID / CHIP

PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Voxzogo - Non-PDL

Phone: 866-841-7659 **Fax back to: 866-240-3712**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:	Prescriber Name:	
Member ID Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Phone Number:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	

Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is this a request for a renewal? If YES, go to Q2. If NO, go to Q4.

☐ Yes ☐ No

Q2. Is the patient prescribed a dose and duration of therapy consistent with the FDA approved package labeling?

☐ Yes ☐ No

Q3. Is there documentation of positive clinical response and/or tolerance to the requested medication?

☐ Yes ☐ No

Q4. Is the patient less 18 years of age?

☐ Yes ☐ No

Q5. Is the patient prescribed a dose and duration of therapy consistent with the FDA approved package labeling?

☐ Yes ☐ No

Jefferson Health Plans

MEDICAID / CHIP

PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Voxzogo - Non-PDL

Phone: 866-841-7659 **Fax back to: 866-240-3712**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:	Prescriber Name:

Q6. Is there a confirmed diagnosis of achondroplasia by one of the following (medical records required):
a. Radiographic findings
OR
b. Genetic testing (FGFR3 mutation)

☐ Yes ☐ No

Q7. Is there documentation confirming patient has open epiphyses?

☐ Yes ☐ No

Q8. Is there documentation of patient's baseline growth velocity?

☐ Yes ☐ No

Q9. Is the patient meeting ALL of the following requirements?
a. No limb-lengthening surgery in the previous 18 months
AND
b. No plans to have limb-lengthening surgery while on Voxzogo.

☐ Yes ☐ No

Q10. Is the patient's eGFR > 60 mL/min/1.73 m2?

☐ Yes ☐ No

Q11. Is there documentation of patient's current actual body weight?

☐ Yes ☐ No

Q12. Is prescribed Voxzogo by or in consultation with a pediatric endocrinologist?

☐ Yes ☐ No

Q13. Additional Information:

Jefferson Health Plans

MEDICAID / CHIP

PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Voxzogo - Non-PDL

Phone: 866-841-7659 **Fax back to: 866-240-3712**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:	Prescriber Name:

Prescriber Signature Date

v2026-06