REALRx

PRIOR AUTHORIZATION REQUEST FORM
DOJOLVI™

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Dojolvi™ (triheptanoin)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is this request for an **expedited** review? By checking the **"Yes"** box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	☐	☐	
2. Is the therapy prescribed by, or in consultation with, a metabolic disease specialist or a physician who specializes in the management of long-chain fatty acid oxidation disorders?	☐	☐	
3. Does the member have a molecularly confirmed diagnosis of a long-chain fatty acid oxidation disorder based on 2 of the following: • Disease-specific acylcarnitine elevations on a newborn blood spot or in plasma • Enzyme activity assay (in cultured fibroblasts or lymphocytes) below the lower limit of normal • Genetic testing demonstrating pathogenic mutations in a gene associated long-chain fatty acid oxidation disorders	☐	☐	**Please provide documentation**
4. Is the member receiving disease related dietary management?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does updated clinical documentation show disease progression or toxicity to therapy?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician Signature:

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Policy: PHARM-112
Origination Date: 12/10/2020
Reviewed/Revised Date: 01/18/2023
Next Review Date: 01/18/2024
Current Effective Date: 02/01/2023