HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM
HYFTOR®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department 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: ☐ Hyftor® (topical sirolimus)

Dosing/Frequency:_____

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

Questions	Yes	No	Comments/Notes
1. Does the member have a definitive diagnosis of tuberous sclerosis complex by meeting one of the following: • Does documentation show identification of a pathogenic variant in the tuberous sclerosis complex 1 (TSC1) gene or tuberous sclerosis complex 2 (TSC2) gene by genetic testing, OR • Clinical documentation shows definitive diagnosis of tuberous sclerosis complex	☐	☐	**Please provide documentation**
2. Is the requesting provider a dermatologist or a prescriber who specializes in the management of individuals with tuberous sclerosis complex or in consultation with one?	☐	☐	**Please provide documentation**
3. Does the member have three or more facial angiofibromas that are at least 2 mm in diameter with redness in each?	☐	☐	**Please provide documentation**
4. Is the member candidate for laser therapy or surgery?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does updated documentation show that the member has a continued medical need?	☐	☐	**Please provide documentation**
3. Does updated documentation show the member responded to therapy, such as a decrease in the size and/or redness of the facial angiofibromas, as determined by the prescriber	☐	☐	**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-CHIP- 145
Origination Date: 07/01/2024
Reviewed/Revised Date: 01/29/2025
Next Review Date: 01/29/2026
Current Effective Date: 02/01/2025