OKLAHOMA Health Care Authority

# State of Oklahoma SoonerCare

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## Hyftor™ (Sirolimus topical gel) Prior Authorization Form

***Member Name:***_____ ***Date of Birth:***_____ ***Member ID#:***_____

## Drug Information

***Pharmacy Billing (NDC:***_____***)*** **Start Date *(or date of next dose):***_____

***Dose:***_____ ***Regimen:***_____

## Billing Provider Information

***Pharmacy NPI:***_____ ***Pharmacy Name:***_____

***Pharmacy Phone:***_____ ***Pharmacy Fax:***_____

## Prescriber Information

***Prescriber NPI:***_____ **Prescriber Name:**_____

***Prescriber Phone:***_____ ***Prescriber Fax:***_____ ***Specialty:***_____

## Criteria

**For Initial Authorization:** *(Initial approvals will be for a duration of 12 weeks)*

1. Does member have a documented diagnosis of facial angiofibromas associated with tuberous sclerosis complex (TSC)? Yes ☐ No ☐
2. Does member have facial angiofibromas that are at least 2mm in diameter with redness in each? Yes ☐ No ☐
3. If member is older than 20 years of age, are medical issues caused by facial angiofibromas? Yes ☐ No ☐
   a. If yes, please provide specific documentation of clinically significant medical issues. (Hyftor™ is not covered for cosmetic use.) _____
   _____
   _____

Additional Information:_____
_____

**For Continued Authorization:**

1. Is the member responding well to treatment? Yes ☐ No ☐
2. Anticipated duration of treatment: _____

Additional Information:_____

**Prescriber Signature:**_____ **Date:**_____

***I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.*** *Failure to complete this form in full will result in processing delays. Please do not send in chart notes. Specific information will be requested if necessary.*

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|---|---|
| Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma.** |  |