

### HEALTH PARTNERS PLANS PRIOR AUTHORIZATION REQUEST FORM

# Vijoice - Non-PDL

Phone: 215-991-4300

Fax back to: 866-240-3712

Health Partners 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  | :                    |  |
|---|------------------|----------------------|--|
| HPP Member Number:  | Fax:             | Phone:               |  |
| Date of Birth:  | Office Contact:  | Office Contact:      |  |
| Member Primary Phone:   | NPI:             | PA PROMISe ID:       |  |
| Address:  | Address:         |                      |  |
| City, State ZIP:  | City, State ZIP: |                      |  |
| Line of Business:   | Specialty Pharma | acy (if applicable): |  |
| Drug Name:  | Strength:        |                      |  |
| Quantity:   | Refills:         |                      |  |
| Directions:   |                  |                      |  |
| Diagnosis Code: Diagnosis Code:   | )iagnosis:       |                      |  |
| HPP's maximum approval time is 12 months but may be less depending on the drug. |                  |                      |  |

| Please attach any pertinent medical history including labs and information for this member that may support approval.<br>Please answer the following questions and sign.  |      |  |
|---|------|--|
| Q1. Is this a request for a renewal? If YES, go to 7.   |      |  |
| □ Yes   | □ No |  |
| Q2. Is the patient 2 years of age or older?   |      |  |
| □ Yes   | □ No |  |
| Q3. Does the patient have a diagnosis of PIK3CA Related Overgrowth Spectrum (PROS) with chart notes attached?   |      |  |
| □ Yes   | □ No |  |
| Q4. Are labs attached confirming presence of a mutation in the PIK3CA gene or likely pathogenic variant as confirmed by genetic testing?  |      |  |
| □ Yes   | □ No |  |
| Q5. Does the patient have severe manifestations of PROS (e.g., severe vascular malformations, chronic gastrointestinal bleeding, severe dyspnea, disabling chronic pain, severe epilepsy, severe manifestations despite previous debulking surgery, excessive tissue growth, scoliosis, vascular tumors, cardiac or renal manifestations, and those that require systemic treatment)? |      |  |

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document



### HEALTH PARTNERS PLANS PRIOR AUTHORIZATION REQUEST FORM

# Vijoice - Non-PDL

Phone: 215-991-4300

Fax back to: 866-240-3712

| Health Partners 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 liste | d above.   |

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

| Member Name:  | Prescriber Name: |  |
|---|------------------|--|
| □ Yes   | □ No             |  |
| Q6. Is the medication prescribed by, or in consultation with, a physician that specializes in treatment of genetic disorders?     |                  |  |
| □ Yes   | □ No             |  |
| Q7. Is there documentation of positive clinical response to VijoiceTM therapy?  |                  |  |
| □ Yes   | □ No             |  |
| Q8. Is there documentation that the patient has not experienced disease progression while receiving VijoiceTM?                    |                  |  |
| □ Yes   | □ No             |  |
| Q9. Is the medication prescribed by, or in consultation with, a physician that specializes in the treatment of genetic disorders? |                  |  |
| □ Yes   | □ No             |  |
| Q10. Additional Information:  |                  |  |
|   |                  |  |
|   |                  |  |

Prescriber Signature

Date

v2025

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document