HIGHMARK HEALTH OPTIONS

Updated: 11/2025
Approved: 11/2025

Request for Prior Authorization for Forzinity (elamipretide)
Website Form – www.wv.highmarkhealthoptions.com
Submit request via: Fax - 1-833-547-2030.

All requests for Forzinity (elamipretide) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Forzinity (elamipretide) Prior Authorization Criteria:

All requests for Forzinity (elamipretide) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Coverage may be provided with a diagnosis of Barth Syndrome and the following criteria is met:

- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- Must be age-appropriate according to FDA-approved labeling, nationally recognized compendia, or evidence-based practice guidelines
- Documentation the diagnosis was confirmed by at least one of the following:
    - A genetic test showing mutations in the TAZ gene
    - An elevated (>0.3) MLCL:CL ratio (monolysocardiolipin to tetralinoleoyl)
- Member weighs at least 30kg.
- Prescribed by or in consultation with a cardiologists, endocrinologists, hematologists, genetics, or neurologists.
- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**
    - Documentation the member has a positive clinical response or stabilization in their disease
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

HIGHMARK HEALTH OPTIONS

Updated: 11/2025
Approved: 11/2025

FORZINITY (ELAMIPRETIDE) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (833)-547-2030.**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: 1-844-325-6251 Mon – Fri 8 am to 7 pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE: _____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:

How was the diagnosis confirmed? (please provide documentation)
☐ Genetic Test
☐ Elevated MLCL:CL ratio

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member experienced an improvement with treatment? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date