



Updated: 11/2025

DMMA Approved: 11/2025

Request for Prior Authorization for Forzinity (elamipretide)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

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:

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.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.



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**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: (855) 476-4158**

If needed, you may call to speak to a Pharmacy Services Representative. **PHONE: (844) 325-6251** Mon – Fri 8:00 am to 7:00 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: <input type="checkbox"/> at a pharmacy OR <input type="checkbox"/> medically, JCODE:
Place of Service: <input type="checkbox"/> Hospital <input type="checkbox"/> Provider's office <input type="checkbox"/> Member's home <input type="checkbox"/> Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:
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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 or stabilization with treatment? Yes No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date