

Prior Authorization Criteria
Skyclarys (omaveloxolone)

All requests for Skyclarys (omaveloxolone) 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 **Friedreich's ataxia** and the following criteria is met:

- Must be prescribed by or in consultation with a neurologist
- Diagnosis has been confirmed by genetic testing
- Must have clinical signs and symptoms (e.g. ataxia, speech disturbance, sensory dysfunction, impaired coordination, frequent falling)
- 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
- **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.



Updated: 05/2024
PARP Approved: 06/2024

**SKYCLARYS (OMAVELOXOLONE)
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 Wholecare Pharmacy Services. **FAX:** (888) 245-2049

If needed, you may call to speak to a Pharmacy Services Representative. **PHONE:** (800) 392-1147 Mon – Fri 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	Provider NPI:
Provider Specialty:	Office Contact:
State license #:	Office NPI:
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:

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:

Has the diagnosis been confirmed by genetic testing? Yes No

Are clinical signs and symptoms present (e.g. ataxia, speech disturbance, sensory dysfunction, impaired coordination, frequent falling)? Yes No

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