

Prior Authorization Criteria
Skyclarys (omaveloxolone)

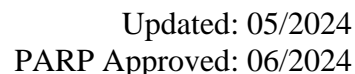
All requests for Skyclarys (omaveloxolone) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

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.



Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Wholcare Pharmacy Services. **FAX:** (888) 245-2049

PROVIDER INFORMATION

MEMBER INFORMATION

REQUESTED DRUG INFORMATION

Billing Information

Place of Service Information

MEDICAL HISTORY (Complete for ALL requests)

CURRENT or PREVIOUS THERAPY

REAUTHORIZATION

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date