Updated: 05/2025
DMMA Approved: 06/2025

Request for Prior Authorization for Vykat XR (diazoxide choline)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Vykat XR (diazoxide choline) 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 **Prader-Willi syndrome (PWS)** and the following criteria is met:

- Member must be ≥ 4 years of age
- Must be prescribed by or in consultation with an endocrinologist or geneticist
- Must provide documentation of BOTH of the following:
  - Genetic testing confirming diagnosis of Prader-Willi syndrome (PWS)
  - Hyperphagia (i.e., persistent sensation of hunger, food preoccupations, an extreme drive to consume food, food-related behavior problems, and a lack of normal satiety)
- Must provide baseline documentation of BOTH of the following:
  - Fasting plasma glucose (FPG)
  - Hemoglobin A1c (HbA1c)
- **Initial duration of approval:** 6 months
- **Reauthorization criteria**
  - Must submit HbA1c within past 3 months
  - FPG within last 3 months
  - Documentation of improvement of hyperphagia symptoms (i.e., persistent sensation of hunger, food preoccupations, an extreme drive to consume food, food-related behavior problems, and a lack of normal satiety)
- **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.

HIGHMARK HEALTH OPTIONS

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VYKAT XR (DIAZOXIDE CHOLINE) 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: ☐ 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 diagnosis of Prader-Willi syndrome been confirmed by genetic testing? ☐ Yes ☐ No
Does the patient have documented hyperphagia? ☐ Yes ☐ No
Has baseline fasting plasma glucose been checked? ☐ Yes ☐ No
Has baseline hemoglobin A1c been checked? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

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

REAUTHORIZATION

Has Hemoglobin A1c been checked within the last 3 months? ☐ Yes ☐ No
Has fasting plasma glucose been checked within the last 4 weeks? ☐ Yes ☐ No

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

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date