



Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Skyclarys (omaveloxolone) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 3 months; Continuation- 6 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Skyclarys (omaveloxolone)**. Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours (fax: 1-866-331-2104). If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: [Pharmacy | Community Provider Portal | Kaiser Permanente](#)

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____ Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #: _____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Drug 2: Name/Strength/Formulation: _____

Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?

Initial therapy Continuing therapy, state start date: _____

2. Indicate the patient’s diagnosis for the requested medication: _____

Clinical Criteria:

1. Prescriber is a Neurologist, Pediatric Neurologist, or Medical Geneticist,
 No Yes
2. **AND** patient is ≥ 16 years and ≤ 40 years of age,
 No Yes
3. **AND** diagnosis of Friedreich's ataxia with confirmatory genetic testing,
 No Yes
4. **AND** modified Friedreich's Ataxia Rating Scale (mFARS) score ≥ 20 and ≤ 80 ,
 No Yes
5. **AND** left ventricular ejection fraction (LVEF) $\geq 40\%$,
 No Yes
6. **AND** patient is using effective contraception, if patient is of childbearing potential
 No Yes

For continuation of therapy, please respond to additional questions below:

1. Documentation of positive clinical response,
 No Yes
2. **AND** specialist follow-up occurred since last review,
 No Yes
3. **AND** documentation of completing the following labs:
 - a. Scr, if patient has clinically significant renal disease
 - b. Liver function tests (ALT, AST, bilirubin), BNP, and lipids No Yes
4. **AND** patient does not have any of the following:
 - a. Increase in transaminase levels $>5X$ ULN or $>3X$ ULN with evidence of liver dysfunction
 - b. Becomes wheelchair bound or non-ambulatory
 - c. Intolerance to medication
 - d. Documented non-adherence to medication
 - e. Pregnancy or breastfeeding No Yes

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:

Date:

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