

Vykat XR (diazoxide choline)**Member and Medication Information**

* indicates required field

*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/ Strength:	
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.	
*Directions for use:	
Provider Information	
* indicates required field	
*Requesting Provider Name:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at 855-828-4992 , to prevent processing delays.	

Criteria for Approval: (All of the following criteria must be met)

- Is the patient 4 years of age or older, and weighs at least 20kg? ☐ Yes ☐ No
- Is Vykat XR being prescribed by or in consultation with a psychiatrist, endocrinologist, or neurologist? ☐ Yes ☐ No
- Does the patient have a genetically-confirmed diagnosis of Prader-Willi syndrome (PWS)? ☐ Yes ☐ No
- Does the patient experience constant extreme hunger that cannot be satisfied by food? ☐ Yes ☐ No
- Will the requesting provider test fasting plasma glucose (FPG) and HbA1c, and optimize blood glucose if the patient has hyperglycemia prior to initiation of Vykat XR? ☐ Yes ☐ No
- Does the provider attest to following recommendations for monitoring and counseling?: ☐ Yes ☐ No
 - ☐ Blood sugar levels weekly for the first 2 weeks of treatment
 - ☐ Blood sugar levels every 4 weeks thereafter
 - ☐ HbA1c every 3 months
 - ☐ Patient and caregiver, as applicable, counseled on signs and symptoms of hyperglycemia, diabetic ketoacidosis, edema, and caution of use for those with compromised cardiac reserve
 - ☐ Medication list was assessed and dosing plan accounted for any potential interactions (including potent CYP1A2 inhibitors, such as fluvoxamine, ciprofloxacin, others)

Name and dose of any CYP1A2 Inhibitors patient will be taking concurrently:

Dosing:

Recommended Once Daily Dosage Regimen				
Weight	Starting Dosage	Titration Dosage	Titration Dosage	Target Maintenance Dosage
	Weeks 1 and 2	Weeks 3 and 4	Weeks 5 and 6	
20 kg to <30 kg	25mg	50mg	75mg	100mg

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30 kg to <40 kg	75mg	150mg	150mg	150mg
40 kg to <65 kg	75mg	150mg	225mg	225mg
65 kg to <100 kg	150mg	225mg	300mg	375mg
100 kg to <135 kg	150mg	300mg	375mg	450mg
135 kg +	150mg	300mg	450mg	525mg
Maximum recommended dosage is 5.8mg/kg/day or 525mg per day. Doses must be decreased if the patient is taking a strong CYP1A2 inhibitor medication concurrently.				

Requested doses: *Medicaid approves specific doses and quantities of medications. Note: Vykat XR is available in 30 count bottles of 25mg, 75mg, and 150mg tablets. Please indicate specific dose:*

	Product	Number of Tablets Per Day	Total Dose per Day	Duration
Starting Dose	☐ 25mg		_____ mg	_____ weeks
	☐ 75mg			
	☐ 150mg			
1st Titration Dose	☐ 25mg		_____ mg	_____ weeks
	☐ 75mg			
	☐ 150mg			
2nd Titration Dose	☐ 25mg		_____ mg	_____ weeks
	☐ 75mg			
	☐ 150mg			
Maintenance Dose	☐ 25mg		_____ mg	
	☐ 75mg			
	☐ 150mg			

Reauthorization Criteria:

- Has the patient had clinically significant improvement in hunger symptoms?
Chart note page #: _____ ☐ Yes ☐ No
- Has the patient been monitored for hyperglycemia by both of the following:?
☐ Blood sugar monitoring at least every 4 weeks
☐ HbA1C at least every 3 months ☐ Yes ☐ No
- Was hyperglycemia not observed, or, if it was, were interventions (e.g., increased monitoring, new pharmacotherapy) initiated to resolve the hyperglycemia?
Details: _____ ☐ Yes ☐ No
- Will the patient continue to be monitored for fluid overload? ☐ Yes ☐ No

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5. Has the prescriber reviewed the patient's medication list for any new, continued, or discontinued medications that interact with Vykat XR, including potent CYP1A2 inhibitors? ☐ Yes ☐ No

Name and dose: _____

6. Patient's current weight: _____

7. Requested Vykat XR dose for reauthorization: _____

	Product	Number of Tablets Per Day	Total Dose per Day	
Maintenance Dose	☐ 25mg		_____ mg	
	☐ 75mg			
	☐ 150mg			

Initial Authorization: Up to six (6) months

Reauthorization: Up to one (1) year

PREScriBER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

Prescriber's Signature

Date

For ADA accommodation or assistance completing this form, please call us at 801-538-6155.