Iowa Department of Human Services

Request for Prior Authorization
Triheptanoin (Dojolvi)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization (PA) is required for triheptanoin (Dojolvi). Payment will be considered under the following conditions:

1) **Request adheres to all FDA approved labeling for indication, including age, dosing, contraindications, warnings and precautions; and**
2) **Patient has a diagnosis of long-chain fatty acid oxidation disorder (LC-FAOD), with supporting documentation of gene mutation(s) associated with LC-FAOD (LC-FAODs include: CPT I, CACT, CPT II, VLCAD, TFP, LCHAD); and**
3) **Patient will not be using another medium chain triglyceride (MCT) product; and**
4) **Documentation of patient's daily caloric intake (DCI) is provided; and**
5) **Patient's target daily dosage is provided as a percentage of the patient's total daily prescribed DCI, not to exceed 35%; and**
6) **Is prescribed by or in consultation with an endocrinologist, geneticist, or metabolic disease specialist.**

If the criteria for coverage are met, initial requests will be approved for four months. Additional authorizations will be considered upon documentation of a positive clinical response to therapy.

Non-Preferred

☐ Dojolvi

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis: _____

Document gene mutation(s) associated with LC-FAOD (attach supporting documentation):

_____

Will patient be using another MCT product? ❑ Yes ❑ No

Provide patient's DCI: _____

Provide target daily dose as a percentage of patient's total daily DCI: _____

Request for Prior Authorization-*Continued*
Triheptanoin (Dojolvi)

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Prescriber Specialty: ❑ Endocrinologist ❑ Geneticist ❑ Metabolic Disease Specialist
❑ Other (specify): _____

If other, note consultation with endocrinologist, geneticist, or metabolic disease specialist:
Consultation date: _____
Physician name, specialty & phone: _____

Renewal Requests

Provide documentation of a positive clinical response to therapy:

_____

_____

_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*