Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health

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Montana Healthcare Programs Prior Authorization Request Form for Use of Hyftor® (sirolimus topical gel 0.2%)

Member name:	DOB:	Date:
Member ID:	Prescriber phone:	
Dosage requested:	Prescriber fax:	

Please complete below information for applicable situation, Initiation or Continuation of therapy:

INITIATION OF THERAPY

1. Member is 6 years of age or older: ☐ Yes ☐ No
2. Member has a diagnosis of facial angiofibroma associated with tuberous sclerosis: ☐ Yes ☐ No
3. Member has three or more angiofibromas on the face that impair eyesight, bleed spontaneously or cause functional impairment: ☐ Yes ☐ No
4. Prescriber attests to the following:
   - ☐ No occlusive dressings will be used.
   - ☐ Provider has discussed vaccination protocol with the member.
   - ☐ Monitoring for adverse reactions due to an increase in systemic exposure of sirolimus will be done if used in conjunction with a CYP3A4 inhibitor.
   - ☐ Provider has discussed with both male and female members, the risk of infertility as well as fetal harm if used during pregnancy.

LIMITATIONS:
Maximum dose allowed:

- 6-11 years of age: two tubes every month
- 12 years of age and older: two tubes every 25 days

Initial authorization will be granted for 12 weeks.

CONTINUATION OF THERAPY

Member has documentation of clinical response to therapy as noted by the reduction in size and redness of facial angiofibroma and decrease in physical impairment compared to baseline: ☐ Yes ☐ No

LIMITATIONS:
Maximum dose allowed:

- 6-11 years of age: two tubes every month
- 12 years of age and older: two tubes every 25 days

Reauthorization will be issued for 1 year.

Please complete form, including required attachments and fax to
Drug Prior Authorization Unit at 1-800-294-1350

11/2022