New Hampshire Medicaid Fee-for-Service Program
Vykat XR (diazoxide choline) Criteria

Approval Date: November 17, 2025

Medications

Brand Names	Generic Names	Indication
Vykat XR	**diazoxide choline**	Treatment of hyperphagia in adults and pediatric patients ≥ 4 years of age with Prader-Willi syndrome (PWS)

Criteria for Approval

1. Patient is 4 years of age or older; **AND**
2. Prescriber is an endocrinologist, geneticist, or specialist in PWS or one has been consulted; **AND**
3. Patient has a diagnosis of Prader-Willi syndrome and **both** of the following:
   a. Presence of hyperphagia; **AND**
   b. Diagnosis has been confirmed by genetic testing indicating mutation on chromosome 15 (medical records required); **AND**
4. Patient does **not** have known hypersensitivity to diazoxide, other components of Vykat XR or thiazides; **AND**
5. Prescriber has reviewed Vykat XR warnings/precautions and drug interactions and will monitor patient status as appropriate.

Initial approval period: 4 months

Criteria for Denial

Failure to meet approval criteria.

Renewal Criteria

1. Patient must continue to meet the above criteria; **AND**
2. Patient must have clinical benefit with the use of Vykat XR (e.g., reduction in hyperphagic and/or food-related behaviors); **AND**
3. Patient has not experienced any treatment-restricting adverse effects (e.g., severe hyperglycemia).

Renewal approval period: 12 months

References

Available upon request.

Revision History

Reviewed By	Reason for Review	Date Approved
DUR Board	New	09/23/2025
Commissioner Designee	Approval	11/17/2025