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New Hampshire Medicaid Fee-for-Service (FFS) Program
Prior Authorization Drug Approval Form
Vykat™ XR (diazoxide choline)

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

FIRST NAME:

MEDICAID ID NUMBER:

DATE OF BIRTH: – –

GENDER: ☐ Male ☐ Female

Drug Name

Strength

Dosing Directions

Length of Therapy

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

FIRST NAME:

SPECIALTY:

NPI NUMBER:

PHONE NUMBER: – –

FAX NUMBER: – –

SECTION III: CLINICAL HISTORY

1. Is the patient 4 years of age and older? ☐ Yes ☐ No
2. Does the patient have a diagnosis of Prader-Willi syndrome (PWS)? ☐ Yes ☐ No
3. Has the diagnosis been confirmed with genetic testing showing mutation on chromosome 15? Attach medical records. ☐ Yes ☐ No
4. Does the patient have hyperphagia? ☐ Yes ☐ No
5. Does the patient have known hypersensitivity to diazoxide or any component of Vykat™ XR or thiazides? ☐ Yes ☐ No
6. Is the prescriber an endocrinologist, geneticist, or a specialist in PWS, or has one been consulted? ☐ Yes ☐ No

Revision Date: 11/01/2025

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PATIENT LAST NAME:

PATIENT FIRST NAME:

7. Prescriber attests to review of warnings/precautions and drug interactions and will monitor the patient status as appropriate. ☐ Yes ☐ No
8. Is there any additional information that would help in the decision-making process?
   If additional space is needed, please use a separate sheet.

SECTION IV: RENEWAL

1. Has the patient had clinical benefit with the use of Vykat™ XR? ☐ Yes ☐ No
2. Has the patient experienced any treatment-restricting adverse effects? ☐ Yes ☐ No

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____