PHENYLKETONURIA
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information please visit *www.myprime.com*. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

☐ Standard review

☐ Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: ___________________

PATIENT AND INSURANCE INFORMATION **Date of Service (if differs from Today's Date): ___________________**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Please select the patient's diagnosis:

☐ Phenylketonuria (PKU)

☐ Other (ICD code, plus description): ____

Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. What is the patient's weight? _________________(kg)
2. Is the patient currently treated with the requested agent? ☐ Yes ☐ No
   If yes, is the patient currently stable on the requested agent? **Please note, chart notes are required.** ☐ Yes ☐ No
3. Is the patient's age within FDA labeling for the requested indication for the requested agent? ☐ Yes ☐ No
   If no, provide support for using the requested agent for the patient's age for the requested indication:________________
   ____
4. Does the patient have any FDA labeled contraindications to the requested agent? ☐ Yes ☐ No
   If yes, please specify FDA labeled contraindications: ____
   ____
5. Will the patient be using the requested agent in combination with another targeted agent included in this program (e.g., Kuvan, Palynziq, sapropterin, Sephience)? ☐ Yes ☐ No
6. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., metabolic disorders), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? ☐ Yes ☐ No
7. Can phenylalanine levels be maintained within the recommended maintenance range with dietary intervention (phenylalanine-restriction) despite strict compliance? ☐ Yes ☐ No
8. Is the patient currently on a phenylalanine (Phe) restricted diet and will continue while being treated with the requested agent? ☐ Yes ☐ No

For Palynziq requests:

9. Is the patient's baseline (prior to therapy with the requested agent) Phe level greater than 600 micromol/L? ☐ Yes ☐ No
   If yes, please specify Phe level: _______________
10. Is the patient's current Phe level less than 360 micromol/L? ☐ Yes ☐ No
    If yes, please specify Phe level: _______________

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

For Kuvan, sapropterin, or Sephience requests:

11. Does the patient have a baseline (prior to therapy for the requested indication) blood Phe level greater than 360 micromol/L? ☐ Yes ☐ No

For brand agent requests:

- **Please submit chart notes to support the answers to the following questions:**

12. Has the patient tried and had an inadequate response to generic sapropterin despite monitored adherence to treatment? ☐ Yes ☐ No
13. Was generic sapropterin discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
14. Does the patient have an intolerance or hypersensitivity to generic sapropterin that is not expected to occur with the requested brand agent? ☐ Yes ☐ No
15. Does the patient have an FDA labeled contraindication to generic sapropterin that is not expected to occur with the requested brand agent? ☐ Yes ☐ No
16. Is generic sapropterin expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; or cause a significant barrier to the patient's adherence of care; or worsen a comorbid condition; or decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; or cause an adverse reaction or cause physical or mental harm? ☐ Yes ☐ No
17. Is generic sapropterin not in the best interest of the patient based on medical necessity? ☐ Yes ☐ No
18. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as generic sapropterin and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
19. Is there support for the use of the requested brand agent over generic sapropterin (e.g., presence of two null mutations)? ☐ Yes ☐ No

    If yes, please provide supporting information: ______________________________

For renewal requests:

20. Has the patient had clinical benefit with the requested agent ☐ Yes ☐ No

    If yes, please explain: ______________________________

Please fax or mail this form to:
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Eagan, MN 55121

TOLL FREE

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