

# UREA CYCLE DISORDERS PRIOR AUTHORIZATION 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](http://www.myprime.com). Start saving time today by filling out this form electronically. Visit [covermy meds.com](http://covermy meds.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**

Patient’s Diagnosis: <input type="checkbox"/> Hyperammonemia <input type="checkbox"/> Other (ICD code plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

**For all requests:**

1. What is the patient’s weight in kg? \_\_\_\_\_
2. What is the patient’s body surface area (m<sup>2</sup>)? \_\_\_\_\_
3. 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
4. Does the patient have any FDA labeled contraindications to the requested agent? .....  Yes  No  
If yes, please specify contraindication(s): \_\_\_\_\_
5. Does the patient have a diagnosis of ONE of the following urea cycle disorders confirmed by enzyme analysis OR genetic testing? (Select any that apply.) .....  Yes  No
  - Carbamoyl phosphate synthetase I deficiency (CPSID)
  - Ornithine transcarbamylase deficiency (OTCD)
  - Argininosuccinic acid synthetase deficiency (ASSD)
  - Argininosuccinic acid lyase deficiency (ASLD)
  - Arginase deficiency (ARG1D)
  - None of the above.
6. Is the patient unable to maintain a plasma ammonia level within the normal range with the use of a protein restricted diet and, when clinically appropriate, essential amino acid supplementation? .....  Yes  No
7. Will the patient be using the requested agent as adjunctive therapy to dietary protein restriction? .....  Yes  No
8. Will the requested agent be used as treatment of acute hyperammonemia? .....  Yes  No
9. 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

**Please continue to the next page.**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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10. Please list all reasons for selecting the requested agent, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** \_\_\_\_\_

\_\_\_\_\_

**For Hyperammonemia requests:**

11. Is the patient a neonate? .....  Yes  No  
 If yes, does the patient have elevated ammonia levels according to the patient's age: plasma ammonia level 150 micromol/L (greater than 260 micrograms/dL) or higher? .....  Yes  No  
 If no, does the patient have elevated ammonia levels according to the patient's age: plasma ammonia level greater than 100 micromol/L (175 micrograms/dL)? .....  Yes  No
12. Does the patient have a normal anion gap? .....  Yes  No
13. Does the patient have a normal blood glucose level? .....  Yes  No

**For Buphenyl and Olpruva requests:**

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

14. Has the patient tried and had an inadequate response to generic sodium phenylbutyrate? .....  Yes  No
15. Was generic sodium phenylbutyrate discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No
16. Does the patient have an intolerance or hypersensitivity to generic sodium phenylbutyrate that is NOT expected to occur with the requested brand agent? .....  Yes  No
17. Does the patient have an FDA labeled contraindication to generic sodium phenylbutyrate that is NOT expected to occur with the requested brand agent? .....  Yes  No
18. Is generic sodium phenylbutyrate 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
19. Is the generic sodium phenylbutyrate not in the best interest of the patient based on medical necessity? .....  Yes  No
20. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as generic sodium phenylbutyrate and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No
21. Is there support for the use of the requested brand agent over generic sodium phenylbutyrate? .....  Yes  No  
 If yes, please provide supporting information: \_\_\_\_\_

**For Ravicti or glycerol phenylbutyrate requests:**

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

22. Has the patient tried and had an inadequate response to generic sodium phenylbutyrate AND Pheburane? .....  Yes  No
23. Were generic sodium phenylbutyrate AND Pheburane discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No
24. Does the patient have an intolerance or hypersensitivity to generic sodium phenylbutyrate AND Pheburane? .....  Yes  No
25. Does the patient have an FDA labeled contraindication to generic sodium phenylbutyrate AND Pheburane? .....  Yes  No
26. Are generic sodium phenylbutyrate AND Pheburane 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
27. Are generic sodium phenylbutyrate AND Pheburane not in the best interest of the patient based on medical necessity? .....  Yes  No
28. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as generic sodium phenylbutyrate AND Pheburane and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No
29. Is there support for the use of the requested brand agent over generic sodium phenylbutyrate AND Pheburane? .....  Yes  No  
 If yes, please provide supporting information: \_\_\_\_\_

**Please continue to the next page.**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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**For renewal requests:**

30. Has the patient had clinical benefit with the requested agent? .....  Yes  No

**Please fax or mail this form to:**  
 Prime Therapeutics LLC  
 Clinical Review Department  
 2900 Ames Crossing Road Suite 200  
 Eagan, MN 55121

**TOLL FREE**

**Phone:** **Fax: 877.243.6930**  
**BCBSIL: 800.285.9426**  
**BCBSMT: 888.723.7443**  
**BCBSNM: 800.544.1378**  
**BCBSOK: 800.991.5643**  
**BCBSTX: 800.289.1525**

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