AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Palynziq™ (pegvaliase-pqpz)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed#: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 6 months.

- ❑ Member is 12 years of age or older
- ❑ Member must have a diagnosis of phenylketonuria **(chart notes must be attached for documentation)**
- ❑ Provider must be a metabolic geneticist or physician knowledgeable in the management of phenylketonuria
- ❑ Baseline current phenylalanine levels must be >600 µmol/L **OR** average phenylalanine levels must have been >600 µmol/L for the last 6 months on existing management **(lab results from within the last 30 days must be attached)**

(Continued on next page)

- ❑ Initial dose must be administered under the supervision of a healthcare provider and auto-injectable epinephrine must be prescribed
- ❑ Medication will **NOT** be used in combination with Kuvan®
- ❑ Member must **NOT** have taken Kuvan® within 14 days of last phenylalanine lab **or** within 14 days of initial therapy with Palynziq™

Reauthorization: 6 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member continues to meet all initial authorization criteria above
- ❑ Phenylalanine levels must have decreased by at least 20% from baseline **OR** phenylalanine blood levels must have decreased to ≤ 600 µmol/L and continue to be maintained at those levels while on maintenance therapy **(labs completed within the last 30 days must be attached)**
- ❑ Medication will **NOT** be used in combination with Kuvan®

Medication being provided by a Specialty Pharmacy – Proprium Rx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

***Approved by Pharmacy and Therapeutics Committee**: ~~7/19/2018;~~ **5/28/2026**
REVISED/UPDATED/REFORMATTED: ~~9/29/2018; 5/22/2019; 11/6/2023;~~ **6/15/2026**