SENTARA COMMUNITY PLAN
(MEDICAID)

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 1-800-750-9692**. 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: Sephience™ (sepiapterin)

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

Member Name: _____

Member Sentara #: _____ **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, if applicable:** _____

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

Recommended Dosage:

Age	Sephience (mg/kg) per day
Less than 6 months	7.5 mg/kg
6 months to less than 1 year	15 mg/kg
1 year to less than 2 years	30 mg/kg
2 years and older	60 mg/kg

Maximum Daily Dose: 60 mg/kg/day

Quantity Limits:

- 250 mg packets – 3 packets per day
- 1000 mg packets – 6 packets per day

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.

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Initial Authorization: 6 months

- ❑ Member is ≥ 1 month of age with a diagnosis of hyperphenylalaninemia with sepiapterin-responsive phenylketonuria
- ❑ Prescriber is a metabolic geneticist or a physician knowledgeable in the management of PKU
- ❑ Member consistently has phenylalanine levels greater than 360 micromol/L **(please attach previous and current baseline labs with levels)**
- ❑ Provider has submitted member's current weight **(please note)**: _____
- ❑ Member is compliant with a protein- and phenylalanine-restricted diet (**please submit chart notes documenting current phenylalanine intake and use of Phe-free medical food supplements**)
- ❑ Requested medication will **NOT** be used in combination with Palynziq® or sapropterin products (Kuvan®, Javygtor™)
- ❑ Member has had trial and intolerable life-endangering adverse event or therapeutic failure with generic sapropterin dihydrochloride **(must submit completed MedWatch form and chart notes/lab test results to document adverse event or therapy failure)**
- ❑ Member will be maintained on a dose no greater than the FDA-approved maximum of 60 mg/kg/day
- ❑ Provider attests that if the member's blood Phe does not decrease after 2 weeks of treatment at the maximum daily dosage of 60 mg/kg, Sephience will be discontinued for lack of biochemical response

Reauthorization: 12 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 must have reduction in phenylalanine level by at least 30% from baseline level after initial approval, and further reduction or stabilization in phenylalanine level below baseline after subsequent approvals **(please attach current labs with level)**
- ❑ Member remains compliant with a protein- and phenylalanine-restricted diet **(please submit chart notes documenting current phenylalanine intake and use of Phe-free medical food supplements)**
- ❑ Provider attests phenylalanine levels will continue to be measured periodically during therapy
- ❑ Provider has submitted member's current weight **(please note)**: _____
- ❑ Requested medication will **NOT** be used in combination with Palynziq® or sapropterin products (Kuvan®, Javygtor™)
- ❑ Member will be maintained on a dose no greater than the FDA-approved maximum of 60 mg/kg/day

Medication being provided by 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**: 9/25/2025
REVISED/UPDATED/REFORMATTED: 10/16/2025