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.**

Sodium Phenylbutyrate Products

Drug Requested: (check applicable box below)

❑ **sodium phenylbutyrate** (Buphenyl®) ❑ **Powder** ❑ **Tablets**	❑ **Pheburane®** (sodium phenylbutyrate) **oral pellets**	❑ **Olpruva™** (sodium phenylbutyrate) **oral suspension**

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:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

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: 12 months

(Continued on next page)

- ❑ Prescriber is a specialist in the management of urea cycle disorders
- ❑ Member's current weight: _____ and height: _____ must be noted
- ❑ Member has a confirmed diagnosis of chronic hyperammonemia due to a urea cycle disorder (UCD) amenable to treatment with sodium phenylbutyrate as verified by genetic, enzymatic or biochemical testing **(submit labs confirming diagnosis)**
- ❑ Member does **NOT** have a diagnosis of UCD with N-acetylglutamate synthase (NAGS) deficiency
- ❑ Sodium phenylbutyrate will **NOT** be used in treatment of acute hyperammonemia
- ❑ Member will be maintained on a protein restricted diet while using sodium phenylbutyrate therapy
- ❑ Member's blood ammonia levels, CBC with differential, hepatic and renal function will be monitored regularly while using this medication

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 has been maintained on a protein restricted diet while using sodium phenylbutyrate therapy
- ❑ Member's current weight: _____ and height: _____ must be noted
- ❑ Member has a documented positive clinical response to therapy and fasting ammonia levels have normalized since last approval of requested medication **(chart notes and/or labs must be submitted)**

Medication being provided by Specialty Pharmacy - PropriumRx

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:** ~~5/19/2022;~~ **11/18/2022**
REVISED/UPDATED/REFORMATTED: ~~5/13/2022; 8/7/2022; 11/29/2022;~~ **12/11/2023**