

# SENTARA HEALTH PLANS

## 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 information provided is not complete, correct, or legible, authorization may be delayed.

**Drug Requested:** glycerol phenylbutyrate (Ravicti®)

**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 Form/Strength: \_\_\_\_\_

Dosing Schedule: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_

Weight (if applicable): \_\_\_\_\_ Date weight obtained: \_\_\_\_\_

**Quantity Limits:** 17.5 mL (19 grams) 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.

**Initial Authorization: 12 months**

- ☐ Prescriber is a specialist in the management of urea cycle disorders
- ☐ Member is 2 months of age or older and current weight: \_\_\_\_\_ and height: \_\_\_\_\_ has been noted by provider
- ☐ Member has a confirmed diagnosis of chronic hyperammonemia due to a urea cycle disorder (UCD) 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
- ☐ Ravicti will **NOT** be used in treatment of acute hyperammonemia

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- ☐ Member has had a 30-day trial and failure of a sodium phenylbutyrate product (generic Buphenyl®, Pheburane®, Olpruva™) as documented by **ONE** of the following:
  - ☐ Fasting ammonia level > 0.5 times the upper limit of normal while compliantly taking a sodium phenylbutyrate product (generic Buphenyl®, Pheburane®, Olpruva™) (**submit labs for documentation**)
  - ☐ Member has a history of intolerance to a sodium phenylbutyrate product (generic Buphenyl®, Pheburane®, Olpruva™) (**submit chart notes documenting clinically significant medication intolerance and completed Med Watch form**)
- ☐ Member will be maintained on a protein restricted diet while using Ravicti® therapy
- ☐ Members with moderate to severe hepatic impairment (Child-Pugh score B or C) will be initiated on 4.5 mL/m<sup>2</sup>/day (**submit current labs including albumin, PT/INR and total bilirubin**)
- ☐ Does the member have some residual enzyme activity? ☐ Yes ☐ No
  - If yes, member must be initiated on 4.5 mL/m<sup>2</sup>/day and titrated according to guidelines

**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 a protein restricted diet while using Ravicti® therapy
- ☐ Member's current weight: \_\_\_\_\_ and height: \_\_\_\_\_ must be noted
- ☐ Member has a documented positive clinical response to Ravicti® therapy and fasting ammonia levels have normalized since last approval of Ravicti® (**submit chart notes and labs to support positive**)

**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.\****