

# SENTARA HEALTH PLANS

## PHARMACY PRIOR AUTHORIZATION 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 may be delayed.**

**Drug Requested:** sapropterin dihydrochloride (Kuvan<sup>®</sup>)

**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/Quantity: \_\_\_\_\_

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

Diagnosis: \_\_\_\_\_ ICD Code, if applicable: \_\_\_\_\_

**RECOMMENDED DOSING:** Initial dose of 10mg/kg/day is recommended, and may be increased to a dose of 20mg/kg/day after 1 month of treatment if phenylalanine levels do not decrease below baseline levels.

**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 Approval: 6 months.**

- Prescriber is a metabolic geneticist or a physician knowledgeable in the management of PKU
- Patient has a diagnosis of hyperphenylalaninemia due to tetrahydrobiopterin (BH4)-responsive phenylketonuria
- Baseline phenylalanine labs must be submitted (**please attach current labs with level**)
- Patient's current weight (**please note**): \_\_\_\_\_
- Patient is compliant with a phenylalanine-restricted diet (**please submit chart notes documenting current phenylalanine intake and use of Phe-free medical food supplements**)

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- Patient does **not** have hepatic or renal impairment
- sapropterin dihydrochloride (Kuvan®) will **NOT** be used in combination with Palynziq™
- For brand name Kuvan approval: Member has had trial and intolerable life-endangering adverse event with generic sapropterin dihydrochloride (must submit completed MedWatch form and chart notes to document adverse event)
- Is patient a pregnant female? (please note):  Yes  No

**Reauthorization Approval: 1 year.** 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.

- Phenylalanine levels have decreased by at least 30% from baseline levels and have remained below baseline (please attach current labs with level)
- Patient remains compliant with a phenylalanine-restricted diet (please submit chart notes documenting current phenylalanine intake and use of Phe-free medical food supplements)
- Phenylalanine levels will continue to be measured periodically during therapy
- Patient's current weight: \_\_\_\_\_
- sapropterin dihydrochloride (Kuvan®) will **NOT** be used in combination with Palynziq™
- For brand name Kuvan approval: Member has had trial and intolerable life-endangering adverse event with generic sapropterin dihydrochloride (must submit completed MedWatch form and chart notes to document adverse event)
- Patient will be maintained on a dose no greater than the FDA-approved maximum of 20mg/kg/day

**\*\*Length of authorization will be for 1 year if approved for continuation.**

**Yearly reauthorization will be required.\*\***

**Medication being provided by a Specialty Pharmacy - PropriumRx**

*Not all drugs may be covered under every Plan*

*If a drug is non-formulary on a Plan, documentation of medical necessity will be required.*

***\*\*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.\****