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.**

Phenylketonuria Products

Drug Requested: (Select drug below)

PREFERRED	
❑ **Kuvan®** (sapropterin) **Powder Packet**	
Non-Preferred	
❑ **Javygtor™** (sapropterin dihydrochloride)	❑ **Kuvan®** (sapropterin) **Tablet**
❑ **sapropterin dihydrochloride** (generic Kuvan®)	❑ **Sephience™** (sepiapterin)
❑ **Zelvysia™** (sapropterin)	

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:** _____

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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.

Authorization: 12 months

For Kuvan Powder packet requests:

- ❑ Member must have a diagnosis of Phenylketonuria

For all other medications:

- ❑ Member must have a diagnosis of phenylketonuria
- ❑ Member must have trial and failure of Kuvan Powder Packet

Medication being provided by a Specialty Pharmacy – Proprium Rx

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.*

***Approved by Pharmacy and Therapeutics Committee**: ~~10/15/2015;~~ **11/20/2025**
REVISED/UPDATED/REFORMATTED: ~~12/21/2016; 8/4/2017; 9/15/2017; 1/16/2019; 3/2/2019; 3/8/2021; 10/11/2021; 10/24/2023; 12/20/2024,12/12/2025;~~ **10/1/2026**