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: Kuvan® (sapropterin dihydrochloride)

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:** _____

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.

For approval of initial 2 month trial, check all applicable boxes below. Attach chart notes to form documenting current labs with level:

- ❑ Prescriber is a metabolic geneticist or a physician knowledgeable in the management of PKU
- ❑ Member has a diagnosis of hyperphenylalaninemia due to tetrahydrobiopterin (BH4)-responsive phenylketonuria
- ❑ Baseline phenylalanine labs must be submitted **(please attach current labs with level)**

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- ❑ Member's current weight **(please note)**: _____
- ❑ Member is compliant with a phenylalanine-restricted diet (**please submit chart notes documenting current phenylalanine intake and use of Phe-free medical food supplements**)
- ❑ Member does **NOT** have hepatic or renal impairment
- ❑ Kuvan® will **NOT** be used in combination with Palynziq®
- ❑ Is the member a pregnant female? **(please note)**: ❑ Yes ❑ No

For continuation of therapy and approval, check ALL applicable boxes below.
Attach current labs with level.
****Length of authorization will be for 1 year if approved for continuation.**
Yearly reauthorization will be required**

- ❑ Phenylalanine levels have decreased by at least 30% from baseline levels and have remained below baseline **(please attach current labs with level)**
- ❑ Member 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
- ❑ Member's current weight _____
- ❑ Kuvan® will NOT be used in combination with Palynziq®
- ❑ **Member will be maintained on a dose no greater than the FDA-approved maximum of 20mg/kg/day**

Medication being provided by a 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.****

***REVISED/UPDATED:** ~~8/26/2017; 8/23/2018; 12/26/2019;~~ **11/7/2023**