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: Palynziq™ (pegvaliase-pqpz)

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 and diagnoses 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: 16 weeks

1. Does member have a diagnosis of phenylketonuria with uncontrolled blood phenylalanine concentrations greater than 600 micromol/L on existing management? ❑ Yes ❑ No

AND

2. Is the member 18 years or older? ❑ Yes ❑ No

AND

(Continued on next page)

3. Must obtain baseline blood phenylalanine concentration before initiating treatment. Is the blood phenylalanine concentration greater than 600 micromol/L? ❑ Yes ❑ No

AND

4. Will administer the initial dose under the supervision of a healthcare provider and train the member and/or caregiver on proper self-administration for future administration? ❑ Yes ❑ No

AND

5. Palynziq™ is available only through a restricted program under a REMS called the Palynziq™ REMS. Is the prescriber certified with the Palynziq™ REMS program? ❑ Yes ❑ No

AND

6. Is member enrolled in the Palynziq™ REMS program and educated on the risks of anaphylaxis? ❑ Yes ❑ No

AND

7. Member MUST have a prescription for auto-injectable epinephrine. ❑ Yes ❑ No

RENEWALS: Approve for one (1) year if member maintains blood phenylalanine concentration reductions of 20% below baseline measurements.

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/REFORMATTED:** ~~10/27/2018; 1/3/2020,~~ **11/9/2023**