OPTIMA HEALTH PLAN

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 will be delayed.**

Drug Requested: Palynziq™ (pegvaliase-pqpz) **Injection**

DRUG INFORMATION: Complete **all** information below or authorization will be delayed.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

CLINICAL CRITERIA. Check below **ALL** that apply. **ALL** criteria **must** be met for approval. **ALL** documentation, including lab results and/or chart notes **(when required)**, **must** be provided or request will be denied.

INITIAL APPROVAL - 6 MONTHS

- ❑ Patient must be at least 18 years old
- ❑ Patient must have a diagnosis of phenylketonuria **(chart notes must be attached for documentation)**
- ❑ Provider must be a metabolic geneticist or physician knowledgeable in the management of phenylketonuria
- ❑ Baseline current phenylalanine levels must be >600 µmol/L **OR** average phenylalanine levels must have been >600 µmol/L for the last 6 months on existing management **(lab results from within the last 30 days must be attached)**
- ❑ Initial dose must be administered under the supervision of a healthcare provider and auto-injectable epinephrine must be prescribed
- ❑ Medication will **NOT** be used in combination with Kuvan®
- ❑ Patient must **NOT** have taken Kuvan® within 14 days of last phenylalanine lab **or** within 14 days of initial therapy with Palynziq™

CONTINUED APPROVAL - 6 MONTHS: ALL criteria below **MUST** be met for approval. **ALL** documentation, including lab results and/or chart notes **(when required)**, **must** be provided or request will be denied.

- ❑ Patient must be at least 18 years old
- ❑ Patient must have a diagnosis of phenylketonuria (chart notes must be attached for documentation)
- ❑ Provider must be a metabolic geneticist or physician knowledgeable in the management of phenylketonuria
- ❑ Phenylalanine levels must have decreased by at least 20% from baseline OR phenylalanine blood levels must have decreased to ≤ 600 µmol/L and continue to be maintained at those levels while on maintenance therapy (labs completed within the last 30 days must be attached)
- ❑ Medication will **NOT** be used in combination with Kuvan®

(continued on next page)

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.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee**: 7/19/2018
REVISED/UPDATED: ~~9/29/2018,~~ **(Reformatted) 5/22/2019**