Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Sapropterin

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the request for brand name Kuvan?

☐ Yes ☐ No

Q2. Is Sapropterin Dihydrochloride being prescribed by or in consultation with a metabolic diseases specialist or a provider who specializes in the treatment of PKU?

☐ Yes ☐ No

Q3. Does the patient have a diagnosis of phenylketonuria confirmed by blood phenylalanine concentrations? Chart notes documenting diagnosis AND labs must be attached.

☐ Yes ☐ No

Q4. Has the patient tried non-pharmacological treatment options (such as restriction of dietary phenylalanine intake)? Notes must be attached showing the patient has tried and failed dietary restriction in consultation with a nutritionist.

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q5. Is there documentation that Sapropterin Dihydrochloride will be used in combination with a Phe-restricted diet? Notes must be attached documenting patient is following a Phe-restricted diet in consultation with a nutritionist.

☐ Yes ☐ No

Q6. Is there documentation showing the patient has tried generic Sapropterin Dihydrochloride for at least one month and has not achieved at least a 20% reduction in blood phenylalanine concentration from baseline at a max dose of 20mg/kg/day or documentation of contraindication/intolerance to generic? Labs must be attached.

☐ Yes ☐ No

Q7. Will this drug be used in combination with Palynziq?

☐ Yes ☐ No

Q8. For renewal: Has the patient been previously approved for treatment?

☐ Yes ☐ No

Q9. Has the patient been compliant with filling their prescription?

☐ Yes ☐ No

Q10. Is the requested medication being used in combination with a phenylalanine (Phe)-restricted diet?

☐ Yes ☐ No

Q11. Has the patient experienced any serious side effects including esophagitis or gastritis?

☐ Yes ☐ No

Q12. Has the patient had at least a 20% reduction in blood phenylalanine concentration from baseline after at least 2 months of therapy at a max dose of 20mg/kg/day? Labs must be attached.

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Patient Name:	**Prescriber Name:**

☐ Yes	☐ No
Q13. Is this drug being used in combination with Palynziq?	
☐ Yes	☐ No
Q14. Additional Information:	

Prescriber Signature _____ Date _____

v2025