



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: <input type="checkbox"/> 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? If YES, go to 6. If NO, go to 2.

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? If YES, go to 3.

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. If YES, go to 4.

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. If YES, go to 5.

Yes No



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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. If YES, go to 7.

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 sapropterin dihydrochloride/formulary alternatives? Labs must be attached. If YES go to 7.

Yes No

Q7. Will the patient receive concomitant Palynziq (pegvaliase-pqpz subcutaneous injection) at a stable maintenance dose? Note: Concomitant use with Palynziq is permitted during Palynziq dose titration. If NO, go to 8.

Yes No

Q8. Will this drug be used in combination with Sepience?

Yes No

Q9. For Renewal: Has the patient been previously approved for treatment?

Yes No

Q10. Has the patient been compliant with filling their prescription?

Yes No

Q11. Is the requested medication being used in combination with a phenylalanine (Phe)-restricted diet?

Yes No

Q12. Has the patient experienced any serious side effects including esophagitis or gastritis?



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Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q13. 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 60mg/kg/day? Labs must be attached.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q14. Will the patient receive concomitant Palynziq (pegvaliase-pqpz subcutaneous injection) at a stable maintenance dose? Note: Concomitant use with Palynziq is permitted during Palynziq dose titration.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q15. Additional Information:	

Prescriber Signature

Date

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