



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Sapropterin Dihydrochloride

Phone: 215-991-4300

Fax back to: 866-240-3712

Health Partners 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.

Form with fields: Patient Name, Prescriber Name, HPP Member Number, Date of Birth, Patient Primary Phone, Address, City, State ZIP, Line of Business, Drug Name, Quantity, Directions, Diagnosis Code, Diagnosis, Strength, Refills, Specialty Pharmacy.

HPP's maximum approval time is 12 months but may be less depending on the drug.

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 this a request for a renewal? If YES, go to 9.

Yes checkbox

No checkbox

Q2. Is the request for brand name Kuvan?

Yes checkbox

No checkbox

Q3. 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 checkbox

No checkbox

Q4. Does the patient have a diagnosis of phenylketonuria confirmed by blood phenylalanine concentrations? Chart notes documenting diagnosis AND labs must be attached.

Yes checkbox

No checkbox

Q5. 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 checkbox

No checkbox

Q6. 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 checkbox

No checkbox

Q7. 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



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Patient Name:	Prescriber Name:
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<p>20mg/kg/day or documentation of contraindication/intolerance to generic? Labs must be attached.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q8. Will this drug be used in combination with Palynziq?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q9. Has the patient been previously approved for treatment?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q10. Has the patient been compliant with filling their prescription?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q11. Has the patient experienced any serious side effects including esophagitis or gastritis?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>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.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q13. Is this drug being used in combination with Palynziq?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q14. Additional Information:</p>

_____ Prescriber Signature	_____ Date
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Updated for 2023