HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Palynziq - Non-PDL

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.

Member Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	

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. Has the patient been approved for treatment with Palynziq previously? If yes, go to Q2. If no, go to Q9.

☐ Yes ☐ No

Q2. Has the patient experienced any serious side effects (such as anaphylactic events) while being treated with Palynziq?

☐ Yes ☐ No

Q3. Has the patient been compliant with filling their prescription?

☐ Yes ☐ No

Q4. Is there documentation that the patient is stable on their current dose of Palynziq? Including documentation showing a blood phenylalanine concentration less than or equal to 600 micromol/L? Labs must be attached. If

☐ Yes ☐ No

Q5. Is there documentation showing the patient has not achieved a blood phenylalanine concentration less than or equal to 600 micromol/L after 24 weeks of continuous treatment with 20 mg subcutaneously once daily?

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☐ Yes ☐ No

Q6. Is there a titration plan in place showing that the patient's dosage will be increased to 40 mg subcutaneously once daily for at least 16 weeks?

☐ Yes ☐ No

Q7. Is there documentation showing the patient has not achieved a blood phenylalanine concentration less than or equal to 600 micromol/L after 16 weeks of continuous treatment with 40 mg subcutaneously once daily? Labs must be attached.

☐ Yes ☐ No

Q8. Is there documentation showing the patient's dosage will be increased to a maximum of 60 mg subcutaneously once daily for at least 16 weeks?

☐ Yes ☐ No

Q9. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q10. Is Palynziq being prescribed by or in consultation with a metabolic diseases specialist or a provider who specializes in the treatment of PKU?

☐ Yes ☐ No

Q11. Does the patient have a diagnosis of uncontrolled phenylketonuria confirmed by baseline blood phenylalanine concentrations greater than 600 micromol/L? Chart notes documenting diagnosis AND baseline labs must be attached.

☐ Yes ☐ No

Q12. 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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Q13. Does the patient have a documented trial and failure of or contraindication/intolerance to sapropterin dihydrochloride (sapropterin dihydrochloride will require Prior Authorization)? Documentation of contraindication/intolerance or trial and failure (at a dose of 20mg/kg for at least 1 month of therapy) must be attached.

☐ Yes ☐ No

Q14. Are both the patient and prescriber enrolled in The Palynziq REMS Program?

☐ Yes ☐ No

Q15. Has auto-injectable epinephrine been prescribed and has the patient been instructed on proper use and to have it on them at all times? Chart notes documenting that auto–injector epinephrine has been prescribed to the patient and counseling has been done must be attached.

☐ Yes ☐ No

Q16. Is there documentation that the initial dose will be administered under the supervision of a healthcare provider?

☐ Yes ☐ No

Q17. Is there documentation showing Palynziq will be initiated at the recommended induction dose?

☐ Yes ☐ No

Q18. Is there documentation showing Palynziq will be titrated over at least 5 weeks after completing the 4-week induction period to an effective maintenance dosage?

☐ Yes ☐ No

Q19. Is there documentation that Palynziq will not be used in combination with sapropterin dihydrochloride (if applicable)?

☐ Yes ☐ No

Q20. Additional Information:

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Member Name:	Prescriber Name:

Prescriber Signature _____ Date _____

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