

**Sapropterin - 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: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:	Diagnosis:		
<i>HPP's maximum approval time is 12 months but may be less depending on the drug.</i>			

**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? 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 Sephience?

 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?

 Yes

 No

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Prescriber Name:

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.

 Yes 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.

 Yes No

Q15. Additional Information:

\_\_\_\_\_  
Prescriber Signature\_\_\_\_\_  
Date

v2026