HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Sephience - 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. Is Sephience 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 2.

☐ Yes ☐ No

Q2. 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 3.

☐ Yes ☐ No

Q3. 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 4.

☐ Yes ☐ No

Q4. Is there documentation that Sephience 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 5.

☐ Yes ☐ No

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Q5. Will this drug be used in combination with sapropterin products? If NO, go to 7.

☐ Yes ☐ No

Q6. 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

Q7. For Renewal: Has the patient been previously approved for treatment?

☐ Yes ☐ No

Q8. Has the patient been compliant with filling their prescription?

☐ Yes ☐ No

Q9. Is the requested medication being used in combination with a phenylalanine (Phe)-restricted diet?

☐ Yes ☐ No

Q10. Has the patient experienced any serious side effects?

☐ Yes ☐ No

Q11. Has the patient had a reduction in blood phenylalanine concentration from baseline at a maximally tolerated dose? Labs must be attached.

☐ Yes ☐ No

Q12. 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

Q13. Additional Information:

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Member Name:	Prescriber Name:

Prescriber Signature _____ Date _____

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