Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Palynziq

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.

Patient Name:	**Prescriber Name:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid □ CHIP	City, State ZIP:	
	Specialty/facility name (if applicable):	

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

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 the patient 18 years of age or older?

☐ Yes ☐ No

Q2. 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

Q3. Does the patient have a diagnosis of uncontrolled phenylketonuria confirmed by blood phenylalanine concentrations greater than 600 micromol/L? Chart notes documenting diagnosis AND labs must be attached.

☐ 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.

☐ Yes ☐ No

Q5. Does the patient have a documented trial and failure of or contraindication/intolerance to Kuvan (Kuvan will require Prior Authorization)? Documentation of contraindication/intolerance or trial and failure (at a dose of 20mg/kg for at least 2 months of therapy) must be attached.

☐ Yes ☐ No

Q6. Are both the patient and prescriber enrolled in The Palynziq REMS Program?

Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Palynziq

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.

Patient Name:	**Prescriber Name:**

☐ Yes	☐ No
Q7. Has auto-injectable epinephrine been prescribed and has the patient been instructed on its 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
Q8. Is there documentation that Palynziq will not be used in combination with Kuvan (if applicable)?	
☐ Yes	☐ No
Q9. Is there documentation of a titration plan in place? Treatment plan must be attached.	
☐ Yes	☐ No
Q10. Requested Duration:	
☐ 4 months	
Q11. Additional Information:	

Prescriber Signature

Date

Updated 2018