Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Kuvan Renewal

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. Has the patient been approved for treatment with Kuvan previously?
☐ Yes ☐ No

Q2. Has the patient been compliant with filling their prescription?
☐ Yes ☐ No

Q3. Has the patient experienced any serious side effects while being treated with Kuvan?
☐ Yes ☐ No

Q4. 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.
☐ Yes ☐ No

Q5. Is Kuvan being used in combination with Palynziq?
☐ Yes ☐ No

Q6. Requested Duration:
☐ 6 months

Q7. Additional Information:

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Patient Name:	**Prescriber Name:**

Prescriber Signature

Date

Updated 2018