



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

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.

Form with two columns: Patient Name and Prescriber Name. Fields include Member Number, Date of Birth, Address, City, State ZIP, Patient Primary Phone, Line of Business (Medicaid, CHIP), Fax, Office Contact, NPI, Promise ID, Prescriber PA PROMISe ID, Address, City, State ZIP, and Specialty/facility name (if applicable).

Expedited/Urgent checkbox

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 checkbox

No checkbox

Q2. Has the patient been compliant with filling their prescription?

Yes checkbox

No checkbox

Q3. Has the patient experienced any serious side effects while being treated with Kuvan?

Yes checkbox

No checkbox

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 checkbox

No checkbox

Q5. Is Kuvan being used in combination with Palyzinq?

Yes checkbox

No checkbox

Q6. Requested Duration:

6 months checkbox

Q7. Additional Information:

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**Patient Name:**

**Prescriber Name:**

Prescriber Signature

Date

*Updated 2018*