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:	
Patient 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. Has the patient been approved for treatment with the requested drug previously?

☐ Yes ☐ No

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

☐ Yes ☐ No

Q3. Has the patient experienced any serious side effects (such as anaphylactic events) while being treated with the requested drug?

☐ Yes ☐ No

Q4. Has the patient had at least a 20 percent reduction in blood phenylalanine concentration from pre-treatment baseline?
[Note: Labs must be attached.]

☐ Yes ☐ No

Q5. Has the patient achieved a blood phenylalanine concentration less than or equal to 600 micromoles per liter after 16 weeks of continuous treatment with the maximum dosage of 40 milligrams subcutaneously once daily?
[Note: Labs must be attached.]

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q7. Is the requested drug being prescribed by or in consultation with a metabolic diseases specialist or a provider who

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specializes in the treatment of phenylketonuria (PKU)?

☐ Yes ☐ No

Q8. Does the patient have a diagnosis of uncontrolled phenylketonuria (PKU) confirmed by blood phenylalanine concentrations greater than 600 micromoles per liter?
[Chart notes documenting diagnosis AND labs must be attached.]

☐ Yes ☐ No

Q9. 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

Q10. Does the patient have a documented trial and failure of, or contraindication or intolerance to Kuvan?
Please note: Kuvan requires prior authorization.
[Documentation of contraindication or intolerance, or trial and failure (at a dose of 20 milligrams per kilogram for at least 1 month of therapy) must be attached.]

☐ Yes ☐ No

Q11. Are both the patient and prescriber enrolled in the Palynziq Risk Evaluation and Mitigation Strategies (REMS) Program?

☐ Yes ☐ No

Q12. 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

Q13. Is there documentation that the requested drug will not be used in combination with Kuvan?

☐ Yes ☐ No

Q14. Is there documentation of a titration plan in place?
[Treatment plan must be attached.]

☐ Yes ☐ No

Q15. Additional Information:

Prescriber Signature

Date

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Updated for 2020