Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Kuvan

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. Is this request for a renewal?

☐ Yes ☐ No

Q2. Is Kuvan 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 phenylketonuria confirmed by blood phenylalanine concentrations? 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. Is there documentation that Kuvan 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.

☐ Yes ☐ No

Q6. Is Kuvan being used in combination with Palynziq?

☐ Yes ☐ No

Q7. Has the patient been approved for treatment with Kuvan previously?

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☐ Yes ☐ No

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

☐ Yes ☐ No

Q9. Has the patient experienced any serious side effects including esophagitis or gastritis while being treated with Kuvan?

☐ Yes ☐ No

Q10. 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

Q11. Is Kuvan being used in combination with Palynziq?

☐ Yes ☐ No

Q12. Additional Information:

____________________________ ____________________

Prescriber Signature Date

Updated for 2021

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