

OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.

Drug Requested: **Kuvan®** (sapropterin dihydrochloride)

DRUG INFORMATION: Complete all information below or authorization process will be delayed.

Drug Form/Strength/Quantity: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

RECOMMENDED DOSING: Initial dose of 10mg/kg/day is recommended, and may be increased to a dose of 20mg/kg/day after 1 month of treatment if phenylalanine levels do not decrease below baseline levels.

CLINICAL CRITERIA: **ALL** boxes **MUST** be checked to qualify. **ALL** chart notes and lab results **MUST** be attached to request. Incomplete documentation will delay authorization process.

For approval of initial 2 month trial, check all applicable boxes below. Attach chart notes to form documenting current labs with level:

- Prescriber is a metabolic geneticist or a physician knowledgeable in the management of PKU
- Patient has a diagnosis of hyperphenylalaninemia due to tetrahydrobiopterin (BH4)-responsive phenylketonuria
- Baseline phenylalanine labs must be submitted (*please attach current labs with level*)
- Patient's current weight (*please note*): _____
- Patient is compliant with a phenylalanine-restricted diet (*please submit chart notes documenting current phenylalanine intake and use of Phe-free medical food supplements*)
- Patient does **not** have hepatic or renal impairment
- Is patient a pregnant female? (*please note*): Yes _____ No _____

For continuation of therapy and approval, check **ALL** applicable boxes below. Attach current labs with level.

****Length of authorization will be for 1 year if approved for continuation. Yearly reauthorization will be required****

- Phenylalanine levels have decreased by at least 30% from baseline levels and have remained below baseline (*please attach current labs with level*)
- Patient remains compliant with a phenylalanine-restricted diet (*please submit chart notes documenting current phenylalanine intake and use of Phe-free medical food supplements*)
- Phenylalanine levels will continue to be measured periodically during therapy
- Patient's current weight _____
- Patient will be maintained on a dose no greater than the FDA-approved maximum of 20mg/kg/day

Medication being provided by a Specialty Pharmacy - PropriumRx

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____