OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION 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 INFORMATON: Complete information below. If incomplete, 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**

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

***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 #: _____

***Approved by Pharmacy and Therapeutics Committee**: 10/15/2015
REVISED/UPDATED: ~~10/23/2015; 12/22/2015; 9/22/2016; 12/21/2016; 8/4/2017;~~ **9/15/2017**