

OPTIMA HEALTH PLAN

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: **Palynziq™ (pegvaliase-pqpz) Injection**

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

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code, if applicable:** _____

CLINICAL CRITERIA – INITIAL 6 MONTH APPROVAL: **ALL** criteria below **MUST** be met for approval. Authorization will be delayed if form is incomplete.

- Patient must be at least 18 years old
- Patient must have a diagnosis of phenylketonuria (**chart notes must be attached for documentation**)
- Provider must be a metabolic geneticist or physician knowledgeable in the management of phenylketonuria
- Baseline current phenylalanine levels must be $>600 \mu\text{mol/L}$ **OR** average phenylalanine levels must have been $>600 \mu\text{mol/L}$ for the last 6 months on existing management (lab results from within the last 30 days must be attached)
- Initial dose must be administered under the supervision of a healthcare provider and auto-injectable epinephrine must be prescribed
- Medication will **NOT** be used in combination with Kuvan®
- Patient must **NOT** have taken Kuvan® within 14 days of last phenylalanine lab or within 14 days of initial therapy with Palynziq™

CONTINUED 6 MONTH APPROVAL: **ALL** criteria below **MUST** be met for approval. Authorization will be delayed if form is incomplete..

- Patient must be at least 18 years old
- Patient must have a diagnosis of phenylketonuria (chart notes must be attached for documentation)
- Provider must be a metabolic geneticist or physician knowledgeable in the management of phenylketonuria
- Phenylalanine levels must have decreased by at least 20% from baseline **OR** phenylalanine blood levels must have decreased to $\leq 600 \mu\text{mol/L}$ and continue to be maintained at those levels while on maintenance therapy (labs completed within the last 30 days must be attached)
- Medication will **NOT** be used in combination with Kuvan®

(continued on next page)

Medication being provided by a Specialty Pharmacy (check applicable box below):

For Optima Commercial Members:

PropriumRx

For Optima Family Care Members:

Sentara Norfolk General CM Pharmacy

****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: 7/19/2018
REVISED/UPDATED: 9/29/2018.