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; **(Pharmacy) 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Ravicti® (glycerol phenylbutyrate) **oral liquid**

DRUG INFORMATION: Complete information below or authorization will be delayed if incomplete.

Drug Form/Strength: _____

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

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

CLINICAL CRITERIA: Check below **ALL** that apply. **ALL** criteria **must** be met for approval. **ALL** documentation including labs or chart notes (if required) **must** be submitted or request will be denied.

Initial Authorization Approval – 12 months

- ❑ Prescriber is a specialist in the management of urea cycle disorders.
- ❑ Member is 2 months of age or older and current weight: _____ and height: _____must be noted.
- ❑ Member has a confirmed diagnosis of chronic hyperammonemia due to a urea cycle disorder (UCD) as verified by genetic, enzymatic or biochemical testing. **(Submit labs confirming diagnosis)**
- ❑ Member does **NOT** have a diagnosis of UCD with N-acetylglutamate synthase (NAGS) deficiency.
- ❑ Ravicti will **NOT** be used in treatment of acute hyperammonemia.
- ❑ Member has had a 30 day trial and failure of sodium phenylbutyrate powder or tablets (generic Buphenyl) with one of the following:
    - ❑ Fasting ammonia level >0.5 times the upper limit of normal while compliantly taking phenylbutyrate oral tablets or powder. **(Submit labs for documentation)**

      OR

    - ❑ Member has history of intolerance to sodium phenylbutyrate oral tablets or powder. **(Submit chart notes documenting clinically significant medication intolerance and completed Med Watch form)**
- ❑ Member will be maintained on a protein restricted diet while using Ravicti® therapy.
- ❑ Members with moderate to severe hepatic impairment (Child-Pugh score B or C) will be initiated on 4.5mL/m^2/day. **(Submit current labs including albumin, PT/INR and total bilirubin)**
- ❑ Does the member have some residual enzyme activity? ❑ Yes ❑ No
    - If yes, member must be initiated on 4.5mL/m^2/day and titrated according to guidelines.

****If approved, maximum daily dose authorized will be 17.5mL (19gm) per day. Authorizations will be approved for 1 year only, then reassessment will be required.****

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<u>Reauthorization of Therapy:</u> Yearly reauthorization is required for continuation of therapy. 12 months.

- ❑ Member has been maintained a protein restricted diet while using Ravicti therapy.
- ❑ Member's current weight: _____ and height: _____ must be noted.
- ❑ Member has a documented positive clinical response to Ravicti® therapy and fasting ammonia levels have normalized since last approval of Ravicti®. **(Submit chart notes and labs to support positive response to therapy)**

Medication being provided by 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:** 3/21/2019;
REVISED/UPDATED: 5/15/2019;