Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

D-Penamine® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Cystinuria
- ❑ Severe Active Rheumatoid Arthritis
- ❑ Wilson's Disease
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Select if the requested medication is prescribed by or in consultation with one of the following specialists:

- ❑ Gastroenterologist
- ❑ Hepatologist
- ❑ Metabolic geneticist
- ❑ Nephrologist
- ❑ Rheumatologist

For Cystinuria, also answer the following:

Does the patient have urinary cystine excretion of > 300mg/day? ❑ **Yes** ❑ **No**

Has the patient had a 30 day trial and failure of potassium citrate or other urinary alkalinizing agent along with sodium and protein-restricted diet and hyperdiuresis (urine output of at least 3L/day)? ❑ **Yes** ❑ **No**

Does the dosing exceed 4gm/day? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following:

Does the patient have urinary cystine excretion of < 200mg/day?¥ ❑ **Yes** ❑ **No**

¥*Labs must be submitted for documentation*

Does the dosing exceed 4gm/day? ❑ **Yes** ❑ **No**

For Severe Active Rheumatoid Arthritis, also answer the following:

Select if the patient has had 30 days trial and failure of the following:

- ❑ Cimzia
- ❑ Humira
- ❑ Simponi

Does the dosing exceed 250mg/day for the first month and 1.5gm/day for maintenance therapy? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following:

Has the patient had shown a clinically significant improvement in rheumatoid arthritis symptoms with chart notes documenting improvement in symptoms? ❑ **Yes** ❑ **No**

Does the dosing exceed 1.5gm/day for maintenance therapy? ❑ **Yes** ❑ **No**

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D-Penamine® Prior Authorization Request Form (Page 2 of 2)

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For Wilson's Disease, also answer the following:

Select if the patient's diagnosis of Wilson's disease is confirmed by one of the following¥:

- ❑ 24-hour urine copper > 40 mcg
- ❑ Liver biopsy with copper dry weight > 250 mcg/g
- ❑ Presence of Kayser-Fleisher rings
- ❑ Serum ceruloplasmin (CPN) < 20mg/dL

¥*Submit labs or chart notes for documentation*

Does the dosing exceed 1.5gm/day? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following:

Is the patient's serum copper level < 10 mcg free copper/dL of serum?¥ ❑ **Yes** ❑ **No**

¥*Labs must be submitted for documentation*

Does the dosing exceed 1.5gm/day? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

Previous therapies failed and/or therapies currently used in combination with the requested medication (*List ALL medications tried or authorization process will be delayed)*:_____

_____

_____

Is the prescribed dose higher than the maximum dose recommendation in FDA-approved labeling (i.e., the package insert)? ❑ **Yes** ❑ **No**

If **Yes**, please provide documentation to support the safety and efficacy of the higher dose (such as evidence from practice guidelines or clinical trials from peer-reviewed medical literature).

*** Please note: Chart documentation of the above is required to be submitted along with this fax*

_____

_____

****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.

Prescriber Signature: _____ **Date:** _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.