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

Kuvan® Prior Authorization Request Form (Page 1 of 2)

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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:

❑ Hyperphenylalaninemia

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Does the patient have hyperphenylalaninemia due to tetrahydrobiopterin (BH4)-responsive phenylketonuria (PKU)? ❑ **Yes** ❑ **No**

Is the prescriber a metabolic geneticist or a physician knowledgeable in the management of PKU? ❑ **Yes** ❑ **No**

Will the patient's baseline phenylalanine labs be submitted? ❑ **Yes** ❑ **No**

Current labs with level must be attached

Is the patient compliant with a phenylalanine-restricted diet? ❑ **Yes** ❑ **No**

Chart notes documenting current phenylalanine intake and use of Phe-free medical food supplements must be submitted

Does the patient have hepatic or renal impairment? ❑ **Yes** ❑ **No**

Document patient's current weight: _____lbs/kg

If female, is the patient pregnant? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization, answer the following:

Has the patient's phenylalanine levels decreased by at least 30% from baseline levels and have remained below baseline? ❑ **Yes** ❑ **No**

Current labs with level must be attached

Does the patient remain compliant with a phenylalanine-restricted diet? ❑ **Yes** ❑ **No**

Chart notes documenting current phenylalanine intake and use of Phe-free medical food supplements must be submitted

Will the patient's phenylalanine levels continue to be measured periodically during therapy? ❑ **Yes** ❑ **No**

Document patient's current weight: _____ lbs/kg

Will the patient be maintained on a dose no greater than the FDA-approved maximum of 20 mg/kg/day? ❑ **Yes** ❑ **No**

Medication being provided by: (Please check applicable box below)

❑ PropriumRx ❑ Specialty Pharmacy (specify name): _____

****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:** _____

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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.

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