# PRIOR AUTHORIZATION REQUEST FORM

**EOC ID:**

# Kuvan (sapropterin)

**Phone: 800-728-7947 Fax back to: 866-880-4532**

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

| **Patient Name:** | **Prescriber Name:**<br>**Supervising Physician:** | |
|---|---|---|
| Member/Subscriber Number: | Fax: | Phone: |
| Date of Birth: | Office Contact: | |
| Group Number: | NPI: | State Lic ID: |
| Address: | Address: | |
| City, State ZIP: | City, State ZIP: | |
| Primary Phone: | Specialty/facility name (if applicable): | |

Drug Name and Strength:

Directions / SIG:

**Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.**

Q1. What diagnosis is this drug being prescribed for?

- ☐ Hyperphenylalaninemia
- ☐ Other (Please Specify)

Q2. Please provide ICD code(s) for diagnosis.

Q3. Will the patient be taking the FDA approved dose of Kuvan?

☐ Yes ☐ No

Q4. Please provide the patient's current weight and the requested dosing regimen.

Q5. Is the patient a NEW START to Kuvan therapy?

☐ Yes ☐ No

Q6. Is the drug being prescribed by a physician knowledgeable in the management of phenylketonuria (PKU)?

☐ Yes ☐ No

Q7. For initial therapy, does the patient have two null mutations in trans?

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| |
|---|
| ☐ Yes ☐ No |
| Q8. Will Kuvan be used in combination with a phenylalanine (PHE)-restricted diet?<br>☐ Yes ☐ No |
| Q9. For RENEWAL requests, has the patient had a reduction in blood PHE, defined as 30% or more from baseline (please submit confirmatory labs)?<br>☐ Yes ☐ No |
| Q10. For RENEWAL requests, has the patient had an increase in dietary PHE tolerance?<br>☐ Yes ☐ No |
| Q11. For RENEWAL requests, does the patient have documented improvement in clinical symptoms (please include clinical documentation for support)?<br>☐ Yes ☐ No |
| Q12. Additional Comments |

Prescriber Signature

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

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| **Patient Name:** | **Supervising Physician:** |