PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Orfadin (nitisinone)

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:** **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. For what diagnosis is this drug being prescribed (pick one)?

☐ Hereditary tyrosinemia type 1 (HT-1)

☐ Other

Q2. Please provide the ICD diagnosis code for the above condition.

Q3. Is Orfadin being prescribed by a specialist experienced in the treatment of Hereditary Tyrosinemia type 1?

☐ Yes ☐ No

Q4. Was the diagnosis of HT-1 confirmed by laboratory or genetic testing (please submit confirmatory clinicals and labs)?

☐ Yes ☐ No

Q5. Will Orfadin be used in combination with tyrosine and phenylalanine dietary restrictions?

☐ Yes ☐ No

Q6. Is the patient's plasma tyrosine level less than 500 micromole/L?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:** **Supervising Physician:**

Q7. What is the patient's current weight and requested dosing regimen?
Q8. Will the patient be taking Orfadin oral suspension at doses greater than 20 ml? ☐ Yes ☐ No
Q9. If taking Orfadin oral suspension at doses greater than 20 ml, is the patient unable to tolerate Orfadin capsules or are they clinically inappropriate? (Please explain) ☐ Yes ☐ No
Q10. 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.