PRIOR AUTHORIZATION REQUEST
Kuvan

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. What is the indication or diagnosis?
   - ☐ Phenylketonuria
   - ☐ Other – Please specify _____
2. Is this the request for initial therapy with Kuvan, or, is this a request for continuation of therapy with Kuvan?
   - ☐ Initial
   - ☐ Continuation
3. ☐ Yes ☐ No Will the medication be prescribed in conjunction with a phenylalanine-restricted diet?
4. ☐ Yes ☐ No Is the medication being prescribed by or in consultation with a metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases)?
5. ☐ Yes ☐ No Has the patient had a clinical response (for example, cognitive and/or behavioral improvements) as determined by the prescriber?
6. ☐ Yes ☐ No Has the patient had a 20% or greater reduction in blood phenylalanine concentration from pre-treatment baseline (that is, blood phenylalanine concentration before starting Kuvan therapy)?
7. ☐ Yes ☐ No Has treatment with Kuvan resulted in an increase in dietary phenylalanine tolerance, according to the prescriber?
8. ☐ Yes ☐ No Will Kuvan be used in combination with Palynziq?

Please document the diagnoses, symptoms, and/or any other information important to this review:

_____

_____

If you have any questions, call: 800-753-2851

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SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

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If you have any questions, call: 800-753-2851