PRIOR AUTHORIZATION REQUEST

Javygtor/Kuvan/Sapropterin

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests.

1 What is the indication or diagnosis?
[] Phenylketonuria (If checked, go to 2)

[] Other (If checked, no further questions)

2 Is this the request for initial therapy or continuation of therapy with the requested medication?
[Note: Patients who have received less than 12 weeks of therapy or those who are restarting therapy with the requested medication should be considered under phenylketonuria - initial therapy.]
[] Initial (If checked, go to 3)

If you have any questions, call:
1-888-258-8250

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	[] Continuation (If checked, go to 5)		
3	Will the requested medication be prescribed in conjunction with a phenylalanine-restricted diet? [If no, no further questions.]	Yes	No
4	Is the requested medication being prescribed by or in consultation with a metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases)? [No further questions.]	Yes	No
5	Has the patient had a clinical response (for example, cognitive and/or behavioral improvements) as determined by the prescriber? [If yes, skip to question 8.]	Yes	No
6	Has the patient had a 20% or greater reduction in blood phenylalanine concentration from pre-treatment baseline (that is, blood phenylalanine concentration before starting therapy with the requested medication)? [If yes, skip to question 8.]	Yes	No
7	Has treatment with the requested medication resulted in an increase in dietary phenylalanine tolerance, according to the prescriber? [If no, no further questions.]	Yes	No
8	Will the requested medication be used in combination with Palynziq?	Yes	No

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

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under

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