maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Phenylbutyrate Products

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 diagnosis or indication? [] Urea Cycle Disorders [Note: Examples include deficiencies of carbamylphosphate synthetase, ornithine transcarbamylase, or argininosuccinic acid synthetase] (If checked, go to 2) [] Other (If checked, no further questions)		
2	Has documentation been provided to confirm that the patient will not be receiving concurrent therapy with another phenylbutyrate product? ACTION REQUIRED: Submit supporting documentation. [NOTE: Examples of phenylbutyrate products include sodium phenylbutyrate, Buphenyl, Olpruva, Pheburane, and Ravicti.] [If no, no further questions.]	Yes	No

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

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3	Has documentation been provided to confirm that the requested medication is being prescribed by or in consultation with a metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
4	Is the patient currently receiving the requested medication? [If no, skip to question 8.]	Yes	No
5	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 8.]	Yes	No
6	Has documentation been provided to confirm that there is documented clinical response of the patient's improvement/stabilization on treatment from baseline? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
7	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [NOTE: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If yes, no further questions.]	Yes	No
8	Has documentation been provided to confirm that the diagnosis of urea cycle disorder was confirmed by enzymatic, biochemical, or genetic analysis involving deficiencies in ONE of the following: A) Carbamylphosphate synthetase (CPS), B) Ornithine transcarbamylase (OTC), OR C) Argininosuccinic acid synthetase (AS)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
9	Has documentation been provided to confirm that the prescriber attests that the requested medication is prescribed in conjunction with a protein-restricted diet? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
10	Has documentation been provided to confirm that the requested medication is not being used to for the treatment of acute hyperammonemia? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
11	Is the patient greater than or equal to 18 years of age? [If yes, skip to question 14.]	Yes	No
12	Has documentation been provided to confirm that the patient's weight is GREATER THAN OR EQUAL TO 20 kg? ACTION REQUIRED: Submit supporting documentation.	Yes	No

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	[If no, no further questions.]		
13	Has documentation been provided to confirm that the patient's body surface area (BSA) is GREATER THAN OR EQUAL TO 1.2 m2? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
14	Has documentation been provided to confirm that the requested dose does not exceed FDA label dosing for the requested indication? ACTION REQUIRED: Submit supporting documentation.	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 the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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