PRIOR AUTHORIZATION REQUEST

Palynziq

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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
2	What is the indication or diagnosis? [] Phenylketonuria (If checked, go to 3) [] Other (If checked, no further questions)		
3	Is this the request for initial therapy or continuation of therapy with the requested medication?		

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

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	[Note: Patients who have received less than 1 year of therapy or those who are restarting therapy with the requested medication should be considered under phenylketonuria - initial therapy.] [] Initial (If checked, go to 4) [] Continuation (If checked, go to 6)		
4	Does the patient have uncontrolled blood phenylalanine concentrations greater than 600 micromol/L on at least one existing treatment modality? [Note: Examples of treatment modalities include restriction of dietary phenylalanine and protein intake and prior treatment with Kuvan (sapropterin dihydrochloride tablets and powder for oral solution).] [If no, no further questions.]	Yes	No
5	Is the requested medication being prescribed by or in consultation with a metabolic disease specialist (or specialist who focuses on the treatment of metabolic diseases)? [No further questions.]	Yes	No
6	Is the patient's blood phenylalanine concentration less than or equal to 600 micromol/L? [If yes, skip to question 8.]	Yes	No
7	Has the patient achieved a 20% reduction or more in blood phenylalanine concentration from pre-treatment baseline (that is, blood phenylalanine concentration before starting therapy with the requested medication)? [If no, no further questions.]	Yes	No
8	Will the requested medication be used in combination with Kuvan?	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

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authorization as per Plan policy and procedures.

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