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. 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 this request for initial therapy or for a continuation of therapy?

[] Initial (If checked, go to 7)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No
[If no, skip to question 7.]

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3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 7.]	Yes	No
4	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 prior authorization (PA) on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been provided to confirm that the patient has had a clinical response to therapy, as evidenced by improvement/stabilization on treatment from baseline? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	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 8) [] Other (If checked, no further questions)		
8	Does the provider attest that the patient will not be receiving concurrent therapy with another phenylbutyrate product? [Note: Examples of phenylbutyrate products include sodium phenylbutyrate, Buphenyl, Olpruva, Pheburane, and Ravicti.] [If no, no further questions.]	Yes	No
9	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
10	Does the provider attest that the requested medication will be prescribed in conjunction with a protein-restricted diet? [If no, no further questions.]	Yes	No
11	Has documentation been provided to confirm that the requested medication is not being used for the treatment of acute hyperammonemia? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No

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12	What medication is being requested? [] Buphenyl (If checked, go to 13) [] Sodium Phenylbutyrate (generic Buphenyl) (If checked, go to 13) [] Olpruva (If checked, go to 19) [] Pheburane (If checked, go to 23) [] Ravicti (If checked, go to 27) [] Other (If checked, no further questions)		
13	Is the request for the brand product, Buphenyl? [If no, skip to question 15.]	Yes	No
14	Does the patient have documented intolerance, contraindication to, or failed treatment for at least 3 months with generic Buphenyl, Sodium Phenylbutyrate? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
15	Is the patient greater than or equal to 1 year of age? [If no, no further questions.]	Yes	No
16	Has documentation been provided to confirm that the patient's weight is GREATER THAN OR EQUAL TO 20 kg? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
17	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)? [If no, no further questions.]	Yes	No
18	Does the requested dose exceed the Food and Drug Administration (FDA) label dosing for the requested indication? [No further questions.]	Yes	No
19	Is the patient greater than or equal to 1 year of age? [If no, no further questions.]	Yes	No
20	Has documentation been provided to confirm that the patient's weight is GREATER THAN OR EQUAL TO 7 kg? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
21	Is the requested medication being prescribed by or in consultation with a	Yes	No

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	metabolic disease specialist (or specialist who focuses on the treatment of metabolic diseases)? [If no, no further questions.]		
22	Does the requested dose exceed the Food and Drug Administration (FDA) label dosing for the indication? [No further questions.]	Yes	No
23	Is the patient greater than or equal to 1 year of age? [If no, no further questions.]	Yes	No
24	Has documentation been provided to confirm that the patient's weight is GREATER THAN OR EQUAL TO 7 kg? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
25	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)? [If no, no further questions.]	Yes	No
26	Does the requested dose exceed the Food and Drug Administration (FDA) label dosing for the indication? [No further questions.]	Yes	No
27	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)? [If no, no further questions.]	Yes	No
28	Does the requested dose exceed the Food and Drug Administration (FDA) label dosing for the requested indication?	Yes	No

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

SECTION B: Physician Signature

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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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