



**2024 PRIOR AUTHORIZATION REQUEST FORM**  
Individual and Family Plans

**Sapropterin**  
Fax back to: (833) 605-4407  
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: <input type="checkbox"/> Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	<b>Specialty/facility name (if applicable):</b>

**REQUEST FOR EXPEDITED REVIEW:** By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

**Please attach any pertinent medical history including labs and information for this member that may support approval.**

**Please answer the following questions and sign.**

Q1. Is the request for brand name Kuvan?

Yes

No

Q2. Is Sapropterin Dihydrochloride being prescribed by or in consultation with a metabolic diseases specialist or a provider who specializes in the treatment of PKU?

Yes

No

Q3. Does the patient have a diagnosis of phenylketonuria confirmed by blood phenylalanine concentrations? Chart notes documenting diagnosis AND labs must be attached.

Yes

No

Q4. Has the patient tried non-pharmacological treatment options (such as restriction of dietary phenylalanine intake)? Notes must be attached showing the patient has tried and failed dietary restriction in consultation with a nutritionist.

Yes

No



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<b>Patient Name:</b>	<b>Prescriber Name:</b>
Q5. Is there documentation that Sapropterin Dihydrochloride will be used in combination with a Phe-restricted diet? Notes must be attached documenting patient is following a Phe-restricted diet in consultation with a nutritionist.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q6. Is there documentation showing the patient has tried generic Sapropterin Dihydrochloride for at least one month and has not achieved at least a 20% reduction in blood phenylalanine concentration from baseline at a max dose of 20mg/kg/day or documentation of contraindication/intolerance to generic? Labs must be attached.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. Will this drug be used in combination with Palynziq?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. For renewal: Has the patient been previously approved for treatment?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Has the patient been compliant with filling their prescription?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q10. Is the requested medication being used in combination with a phenylalanine (Phe)-restricted diet?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q11. Has the patient experienced any serious side effects including esophagitis or gastritis?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q12. Has the patient had at least a 20% reduction in blood phenylalanine concentration from baseline after at least 2 months of therapy at a max dose of 20mg/kg/day? Labs must be attached.	



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Form with fields for Patient Name, Prescriber Name, and checkboxes for Yes/No answers to questions Q13 and Q14.

Prescriber Signature

Date

2024 Prior Authorization Request