HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
PHENYLBUTYRATES
Buphenyl®, Pheburane®, Ravicti®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ sodium phenylbutyrate powder, ☐ sodium phenylbutyrate tablets
Non-preferred: ☐ Pheburane® (sodium phenylbutyrate)
Non-formulary: ☐ Ravicti® (glycerol phenylbutyrate)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Does the member have a diagnosis of urea cycle disorder requiring chronic management that is confirmed by enzymatic, biochemical or genetic testing?	☐	☐	**Please provide documentation**
2. Does documentation show that the member's condition has not been managed adequately by dietary protein restriction and/or amino acid supplementation alone?	☐	☐	**Please provide documentation**
3. Has a nutritional consultation been performed to assess diet?	☐	☐	**Please provide documentation**
4. Will phenylbutyrate be used in combination with a dietary protein restriction?	☐	☐	**Please provide documentation**
5. Does the requesting provider specialize in the treatment of urea cycle disorder?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does updated documentation show a continued medical necessity and clinical efficacy of therapy?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician's Signature:

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Policy PHARM-058
Origination Date: 05/07/2015
Reviewed/Revised Date: 10/26/2022
Next Review Date: 10/26/2023
Current Effective Date: 11/01/2022