

HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM

PHENYLKENTONUIRA

Kuvan®, Palynziq®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 385-425-4052.

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: 385-425-5094

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: Sapropterin dihydrochloride

Non-preferred: Palynziq® (pegvaliase-pqpz)

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Does the member have a confirmed diagnosis of phenylketonuria?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Is the member followed by a physician who specializes in metabolic diseases?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the member followed by a dietician who specializes in PKU/metabolic diseases?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Has the member been compliant with and failed a phenylalanine restricted diet for at least 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Do average Phe levels within 2 weeks of therapy initiation show the following? <ul style="list-style-type: none"> • >6 mg/dL for ages 1 month to 12 years • >15 mg/dL after the age of 12 • >6 mg/dL in pregnancy. 	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

PALYNZIQ®

1. Is sapropterin dihydrochloride or Palynziq® being requested to liberalize a strict phenylalanine restricted diet? Authorization will not be provided for liberalizing diet or in non-compliant patients.	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has a trial and failure of the maximally tolerated dose of sapropterin dihydrochloride been demonstrated?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

3. In women of childbearing potential, will contraception be used prior to and during treatment?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member remained compliant with a phenylalanine-restricted diet?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Has there been a documented positive clinical response from treatment? <ul style="list-style-type: none"> Defined as a $\geq 20\%$ decrease from baseline in Phe levels after 12 weeks or maintenance of initial reduction. 	<input type="checkbox"/>	<input type="checkbox"/>	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-CHIP-059
 Origination Date: 07/01/2024
 Reviewed/Revised Date:
 Next Review Date:
 Current Effective Date: 07/01/2024

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