REALRx

Healthy U
Health Choice Utah

PRIOR AUTHORIZATION REQUEST FORM

PHENYLKENTONUIRA

Kuvan®, Palynziq®

For authorization, please answer each question and fax this form PLUS chart notes back to the RealRx Medicaid 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 Pharmacy Customer Service for assistance.

- Healthy U Medicaid: 855-856-5694
- Health Choice Utah: 855-864-1404

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?	☐	☐	**Please provide documentation**
2. Is the member followed by a physician who specializes in metabolic diseases?	☐	☐	
3. Is the member followed by a dietician who specializes in PKU/metabolic diseases?	☐	☐	
4. Has the member been compliant with and failed a phenylalanine restricted diet for at least 6 months?	☐	☐	**Please provide documentation**
5. Do average Phe levels within 2 weeks of therapy initiation show the following? • *>6 mg/dL for ages 1 month to 12 years* • *>15 mg/dL after the age of 12* • *>6 mg/dL in pregnancy.*	☐	☐	**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.	☐	☐	

2. Has a trial and failure of the maximally tolerated dose of sapropterin dihydrochloride been demonstrated?	☐	☐	**Please provide documentation**
3. In women of childbearing potential, will contraception be used prior to and during treatment?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member remained compliant with a phenylalanine-restricted diet?	☐	☐	**Please provide documentation**
3. Has there been a documented positive clinical response from treatment? • Defined as a ≥20% decrease from baseline in Phe levels after 12 weeks or maintenance of initial reduction.	☐	☐	**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:

PRESCRIBER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

Physician's Signature:	**Date:**

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Policy: PHARM-MM-059
Origination Date: 01/01/2022
Reviewed/Revised Date: 06/11/2025
Next Review Date: 06/11/2026
Current Effective Date: 07/01/2025