Buphenyl, Olpruva, Pheburane [sodium phenylbutyrate]

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What is the prescribed drug?
   ❑ Buphenyl ❑ Pheburane ❑ sodium phenylbutyrate ❑ Olpruva ❑ Other _____
2. What is the patient's diagnosis? ❑ Urea cycle disorder ❑ Other _____
3. What is the ICD-10 code? _____
4. What is the patient's weight? _____ kg

Requests for Olpruva

5. Coverage for the requested drug is provided when the patient has tried and had a treatment failure with all or at least three of the formulary medications. The formulary alternative for the requested drug is sodium phenylbutyrate. Can the patient's treatment be switched to the formulary alternative? ***If Yes, please fax a new prescription to the pharmacy and skip to #15***
   ❑ Yes, please specify: _____
   ❑ No - Continue request for non-preferred drug.
6. Has the patient tried and had a documented inadequate response or intolerable adverse reaction to all or at least three of the formulary alternative(s)? Note: Formulary medications should be prescribed first unless the patient is unable to use or receive treatment with the alternative. ❑ Yes ❑ No

   Formulary alternative(s): sodium phenylbutyrate

   If Yes, indicate the drug the patient has tried and the reason for treatment failure and skip to #8

   Drug name: _____ Reason for treatment failure: _____
7. Does the patient have a documented contraindication to all or at least three of the formulary alternative(s): sodium phenylbutyrate? ❑ Yes ❑ No

   If Yes, indicate the drug the patient is unable to take and describe the contraindication.

   Drug name: _____ Contraindication: _____

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization. Fax: 1-866-249-6155

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8. Has chart note(s) or other documentation supporting the inadequate response, intolerable adverse reaction, or contraindication to the necessary number of formulary alternatives been submitted? ***ACTION REQUIRED: Submit chart note(s) or other documentation indicating prior treatment failure, severity of the adverse event (if any), and dosage and duration of the prior treatment, or contraindication to formulary alternatives.***
If Yes, skip to #15 ❑ Yes ❑ No

Requests for Buphenyl

9. Has the patient failed treatment with the generic medication due to an intolerable adverse event (e.g., rash, nausea, vomiting)? ❑ Yes ❑ No

10. Was the intolerable adverse event an expected adverse event attributed to the ACTIVE ingredient as described in the prescribing information (i.e., known adverse reaction for both the brand and generic medication)?
❑ Yes ❑ No

11. Was this adverse event documented in the patient's chart? ***ACTION REQUIRED: If Yes, documentation is required for approval. Provide SPECIFIC and DETAILED chart documentation including description, date/time, and severity of the adverse event, dosage and duration of generic medication treatment, required intervention (if any), and relevant tests or laboratory data (if any) OR MedWatch form of this trial and failure including the adverse reaction.*** ❑ Yes ❑ No

12. Is the product being requested for the treatment of urea cycle disorders? ❑ Yes ❑ No *If No, skip to #15*

13. The preferred product for your patient's health plan is sodium phenylbutyrate. Can the patient's treatment be switched to the preferred product? ***If Yes, fax a new prescription to the pharmacy and skip to #15.***
❑ Yes ❑ No ❑ Not applicable - sodium phenylbutyrate is being prescribed, *skip to #15*

14. Does the patient have a documented intolerable adverse event to the preferred product (sodium phenylbutyrate) that was NOT an expected adverse event attributed to the active ingredient as described in the prescribing information? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No

All Requests

15. Will the requested medication be used for chronic management of a urea cycle disorder (UCD), including arginase deficiency? ❑ Yes ❑ No

16. Is this request for continuation of treatment with the requested medication?
If Yes, skip to #19 ❑ Yes ❑ No

17. Was the diagnosis confirmed by enzymatic, biochemical, or genetic testing? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) or enzyme assay, biochemical, or genetic testing results supporting diagnosis.***
❑ Yes ❑ No

18. Does the patient have elevated plasma ammonia levels at baseline? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) or lab results for plasma ammonia levels and no further questions.*** ❑ Yes ❑ No

19. Does the patient have a body surface area (BSA) of 1.2 m^2 or greater? ❑ Yes ❑ No

20. Is the patient experiencing benefit from therapy with the requested medication as evidenced by a reduction in plasma ammonia levels from baseline? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) or lab results for plasma ammonia levels.*** ❑ Yes ***q*** No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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