

Member Name: {{MEMFIRST}} {{MEMLAST}} DOB: {{MEMBERDOB}} PA Number: {{PANUMBER}}



{{PANUMCODE}}

Kuvan

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.

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Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date:** {{TODAY}}
Patient's ID {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

- What is the diagnosis?
 Phenylketonuria
 Bioppterin metabolic defects
 Autosomal dominant guanine triphosphate cyclohydrolase deficiency (Segawa disease)
 Autosomal recessive guanine (GTP) cyclohydrolase deficiency
 6-pyruvoyl-tetrahydropterin synthase (6-PTS) deficiency
 Sepiapterin reductase deficiency
 Dihydropteridine reductase (DHPR) deficiency
 Pterin-4a-carbinolamine dehydralase deficiency (also called primapterinuria)
 Other _____
- What is the ICD-10 code? _____
- Was the diagnosis confirmed by an enzyme assay, genetic testing, or phenylalanine level?
ACTION REQUIRED: If Yes, attach supporting chart note(s) or test results. Yes No
- Is this request for continuation of therapy with Kuvan? *If Yes, skip to diagnosis section.* Yes No
- Is Kuvan being requested for a bioppterin metabolic defect? *If Yes, no further questions* Yes No
- What is the patient's baseline (with dietary interventions alone) blood phenylalanine (Phe) level?
_____ mg/dL or micromol/L (**circle one**) No baseline blood Phe level
- Will Kuvan be initiated in a patient currently receiving Palynziq for phenylketonuria?
 Yes No *If No, no further questions*
- Will Palynziq be discontinued after an appropriate period of overlap? Yes No *No further questions*

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Phenylketonuria

- Which of the following has the patient demonstrated following the therapeutic trial with Kuvan?
Question continues on next page.
 Reduction in blood phenylalanine (Phe) level of greater than or equal to 30% from baseline

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

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Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

- Phenylalanine (Phe) levels in an acceptable range (less than 360 micromol/L or 6 mg/dL)
- Improvement in neuropsychiatric symptoms
- None of the above

10. Will Kuvan be used concomitantly with Palynziq for phenylketonuria? Yes No

Section B: Biotpterin Metabolic Defects

11. Is the patient experiencing benefit from therapy as evidenced by disease stability or disease improvement?

- Yes - disease stability
- Yes - disease improvement
- No, neither disease stability nor disease improvement

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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