Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health
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Montana Healthcare Programs Prior Authorization Request Form for Use of Kuvan (sapropterin)

Member Name:	Date:
Member ID:	DOB:
Prescriber Name:	Specialty:
Prescriber Phone:	Prescriber Fax:
Dose requested:	Current Member Weight:

Please complete below information for applicable situation, Initiation or Continuation of therapy:

☐ INITIATION OF THERAPY

- Prescriber is a specialist with knowledge and expertise in metabolic or genetic diseases ☐ Yes ☐ No
- Laboratory results are attached:
  - Confirming member has a diagnosis of phenylketonuria ☐ Yes ☐ No
  - Documenting an elevated baseline blood phenylalanine (Phe) level (*taken from an average of fasting Phe blood levels ideally drawn in the morning*) measured within 2 weeks prior to Kuvan initiation:_____ µmol/L or mg/dL Date:_____
- Member is on a phenylalanine restricted diet and Phe levels cannot be maintained within the recommended maintenance range [120-360 µmol/L (2-6 mg/dL)] with diet alone ☐ Yes ☐ No

Dosing, Quantity Limitations, Authorization Period:
Quantity Limits: Up to 10 mg/kg/day for up to 2 months as initial treatment. Up to 20 mg/kg/day may be authorized if clinical documentation is provided that initial treatment with at least 8 days of 10 mg/kg/day is not effective. *Effectiveness is defined as at least a 30% decrease in blood Phe level from baseline.*

- Note: Number of tablets (or powder packets for solution) authorized per month will be rounded to the nearest 100 mg. Doses exceeding 20 mg/kg/day will not be authorized.
- **Initial authorization will be issued for 2 months.** If Phe levels have not decreased in this time, member is considered a "non-responder" and further authorization will not be granted.

☐ CONTINUATION OF THERAPY

- Member has continued Phe restricted diet and provider attests that Kuvan has been effective in maintaining Phe levels within the recommended range ☐ Yes ☐ No
- **Reauthorization will be issued for 12 months.**

Please complete form, including required attachments and fax to:
Drug Prior Authorization Unit
1-800-294-1350