Montana Healthcare Programs Prior Authorization Request Form for Use of Kuvan (sapropterin)

<table>
<thead>
<tr>
<th>Member Name:</th>
<th>Date:</th>
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<tbody>
<tr>
<td>Member ID:</td>
<td>DOB:</td>
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<tr>
<td>Prescriber Name:</td>
<td>Specialty:</td>
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<tr>
<td>Prescriber Phone:</td>
<td>Prescriber Fax:</td>
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<tr>
<td>Dose requested:</td>
<td>Current Member Weight:</td>
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</tbody>
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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