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 Palynziq (pegvaliase-pqpz)

MemberName:	Date:
Member ID:	DOB:
Prescriber Name:	Specialty:
Prescriber Phone:	Prescriber Fax:
Dose Requested:	

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

☐ INITIATION OF THERAPY

- Member is 18 years of age or older ☐ Yes ☐ No
- Prescriber is a specialist with knowledge and expertise in metabolic or genetic diseases ☐ Yes ☐ No
- Member has a diagnosis of phenylketonuria ☐ Yes ☐ No
- Laboratory results/chart notes are attached confirming member is on a phenylalanine restricted diet and/or Kuvan (sapropterin) and Phe levels cannot be maintained < 600µmol/L ☐ Yes ☐ No
  Current Phe concentration:_____ µmol/L Date:_____
- Has the memberbeen prescribed auto-injectable epinephrine and been instructed in its use? ☐ Yes ☐ No

Authorization Period: Initial authorization will be issued for 6 months to allow for flexibility in titration schedule.

☐ CONTINUATION OF THERAPY

- Member has continued Phe restricted diet and laboratory results **are attached** documenting:
  - Member has a blood phenylalanine concentration < 600µmol/L ☐ Yes ☐ No **OR**
  - Member has achieved a 20% reduction in blood phenylalanine concentration from pre-treatment baseline ☐ Yes ☐ No Current Phe concentration _____ µmol/L Date: _____ **OR**
  - Member is in initial titration/maintenance phase of dosing regimen (week 1-33) **AND** member will receive a dose increase of 40mg once daily if response has not been obtained after 24 weeks of 20mg once daily maintenance dosing. If response is not achieved with 40mg for 16 weeks, dose may be increased to 60mg daily for maximum dose. ☐ Yes ☐ No

Reauthorization will be issued for 12 months for maximum 60mg daily dose. If no response after 16 weeks of continuous 60mg daily dose, no further approval will be granted.

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