PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 8/12/2024
Patient ID: _____ **Patient Date Of Birth:**
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
_____ **Physician Office Telephone:**
Physician Office Address: _____
_
Drug Name (specify drug) _____
Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____
Comments: _____
_____
_____

Please check the appropriate answer for each applicable question.

1. What is the diagnosis?
   - Phenylketonuria (If checked, go to 2) ☐
   - Biopterin metabolic defects - Autosomal dominant guanine triphosphate cyclohydrolase deficiency (Segawa disease) (If checked, go to 2) ☐
   - Biopterin metabolic defects - Autosomal recessive guanine (GTP) cyclohydrolase deficiency (If checked, go to 2) ☐
   - Biopterin metabolic defects - 6-pyruvoyl-tetrahydropterin synthase (6-PTS) deficiency (If checked, go to 2) ☐
   - Biopterin metabolic defects - Sepiapterin reductase deficiency (If checked, go to 2) ☐
   - Biopterin metabolic defects - Dihydropteridine reductase (DHPR) deficiency (If checked, go to 2) ☐
   - Biopterin metabolic defects - Pterin-4a-carbinolamine dehydratase deficiency (also called primapterinuria) (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

     _____

2. Was the diagnosis confirmed by an enzyme assay, genetic testing, or phenylalanine level? **Y** ☐ **N** ☐
   ACTION REQUIRED: If Yes, attach supporting chart note(s) or test results.
   ACTION REQUIRED: Submit supporting documentation

3. Is this request for continuation of therapy with the requested medication? **Y** ☐ **N** ☐

4. Is the requested medication being requested for a biopterin metabolic defect? **Y** ☐ **N** ☐

5. What is the patient's baseline (with dietary interventions alone) blood phenylalanine (Phe) level?
   - Greater than or equal to 6 mg/dL (greater than or equal to 360 micromol/L) (If checked, go to 6) ☐
   - Less than 6 mg/dL (less than 360 micromol/L) (If checked, no further questions) ☐
   - No baseline blood Phe level (If checked, no further questions) ☐

6. Will the requested medication be initiated in a patient currently receiving Palynziq for phenylketonuria? **Y** ☐ **N** ☐

7. Will Palynziq be discontinued after an appropriate period of overlap? **Y** ☐ **N** ☐

8. What is the diagnosis?

- Phenylketonuria (If checked, go to 9) ☐
- Biopterin metabolic defects - Autosomal dominant guanine triphosphate cyclohydrolase deficiency (Segawa disease) (If checked, go to 11) ☐
- Biopterin metabolic defects - Autosomal recessive guanine (GTP) cyclohydrolase deficiency (If checked, go to 11) ☐
- Biopterin metabolic defects - 6-pyruvoyl-tetrahydropterin synthase (6-PTS) deficiency (If checked, go to 11) ☐
- Biopterin metabolic defects - Sepiapterin reductase deficiency (If checked, go to 11) ☐
- Biopterin metabolic defects - Dihydropteridine reductase (DHPR) deficiency (If checked, go to 11) ☐
- Biopterin metabolic defects - Pterin-4a-carbinolamine dehydratase deficiency (also called primapterinuria) (If checked, go to 11) ☐
- Other, please specify. (If checked, no further questions) ☐

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9. Which of the following has the patient demonstrated following the therapeutic trial with the requested medication?

- Reduction in blood phenylalanine (Phe) level of greater than or equal to 30% from baseline (If checked, go to 10) ☐
- Phenylalanine (Phe) levels in an acceptable range (less than 360 micromol/L or 6 mg/dL) (If checked, go to 10) ☐
- Improvement in neuropsychiatric symptoms (If checked, go to 10) ☐
- None of the above (If checked, no further questions) ☐

10. Will the requested medication be used concomitantly with Palynziq for phenylketonuria? **Y** ☐ **N** ☐

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

- Yes, disease stability (If checked, no further questions) ☐
- Yes, disease improvement (If checked, no further questions) ☐
- No, neither disease stability nor disease improvement (If checked, no further questions) ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

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Prescriber (Or Authorized) Signature and Date