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

{{PANUMCODE}}

{{DISPLAY_PAGNAME}}
{{PACDESCRIPTION}}

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to {{COMPANY_NAME}} at {{CLIENT_PAG_FAX}}. Please contact {{COMPANY_NAME}} at {{CLIENT_PAG_PHONE}} with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of {{DRUGNAME}}.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}} **Patient Phone:** <<MEMPHONE>>
Specialty: _____ **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Physician Office Address: <<PHYADDRESS1>> <<PHYADDRESS2>> <<PHYCITY>>, <<PHYSTATE>> <<PHYZIP>>
Drug Name: {{DRUGNAME}}

Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: <<DIAGNOSIS>> **ICD Code**: <<ICD9>>

1. What is the prescribed drug?
   ❑ Buphenyl ❑ Pheburane ❑ sodium phenylbutyrate ❑ Olpruva ❑ Other _____
2. What is the patient's diagnosis? ❑ Urea cycle disorder ❑ Other _____
3. What is the ICD-10 code? _____
4. What is the patient's weight? _____ kg

Requests for Olpruva

5. Coverage for the requested drug is provided when the patient has tried and had a treatment failure with at least three of the formulary medications, or all of the formulary alternatives if there are fewer than three. The formulary alternatives for the requested drug are sodium phenylbutyrate and Pheburane. Can the patient's treatment be switched to the formulary alternative? ***If Yes, please fax a new prescription to the pharmacy and skip to #12***
   ❑ Yes, please specify: _____
   ❑ No - Continue request for non-preferred drug
6. Has the patient tried and had a documented inadequate response or intolerable adverse reaction to at least three of the formulary medications, or all of the formulary alternatives if there are fewer than three? Note: Formulary medications should be prescribed first unless the patient is unable to use or receive treatment with the alternative.
   ❑ Yes ❑ No

   Formulary alternative(s): sodium phenylbutyrate, Pheburane

   If Yes, indicate the formulary alternative(s) the patient has tried and the reason(s) for treatment failure and skip to #8

   Drug name: _____ Reason for treatment failure: _____
7. Does the patient have a documented contraindication to all or at least three of the formulary alternative(s): sodium phenylbutyrate, Pheburane? ❑ Yes ❑ No

   If Yes, specify the formulary alternative(s) the patient is unable to take and describe the contraindication(s).

   Drug name: _____ Contraindication: _____

8. Have chart notes or other documentation supporting the inadequate response, intolerable adverse reaction, or contraindication to at least three of the formulary medications, or all of the formulary alternatives if there are fewer than three been attached? ***ACTION REQUIRED: Submit chart note(s) or other documentation indicating prior treatment failure, severity of the adverse event (if any), and dosage and duration of the prior treatment, or contraindication to formulary alternatives.***
   If Yes, skip to #12 ❑ Yes ❑ No

Requests for Buphenyl

9. The preferred products for your patient's health plan are generic sodium phenylbutyrate and Pheburane. Can the patient's treatment be switched to a preferred product? ***If Yes, fax a new prescription to the pharmacy and skip to #12.*** ❑ Yes - ***Please specify:*** _____ ❑ No

10. Does the patient have a documented intolerable adverse event to treatment with both of the preferred products (generic sodium phenylbutyrate and Pheburane)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s)..*** ❑ Yes ❑ No

11. Was the documented intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information? ***ACTION REQUIRED: If No, attach supporting chart note(s).*** ❑ Yes ❑ No

All Requests

12. Will the requested medication be used for chronic management of a urea cycle disorder (UCD), including arginase deficiency? ❑ Yes ❑ No

13. Is this request for continuation of treatment with the requested medication?
    If Yes, skip to #17 ❑ Yes ❑ No

14. Was the diagnosis confirmed by enzymatic, biochemical, or genetic testing? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) or enzyme assay, biochemical, or genetic testing results supporting diagnosis.*** ❑ Yes ❑ No

15. Does the patient have elevated plasma ammonia levels at baseline? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) or lab results for plasma ammonia levels and no further questions.*** ❑ Yes ❑ No

16. Does the patient have a body surface area (BSA) of 1.2 m^2 or greater? ❑ Yes ❑ No

17. Is the patient experiencing benefit from therapy with the requested medication as evidenced by a reduction in plasma ammonia levels from baseline? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) or lab results for plasma ammonia levels.*** ❑ Yes ❑ No

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.

_____

Prescriber (Or Authorized) Signature and Date