



Federal Employee Program.

SEPHIENCE PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)				Provider Information (required)		
Date:				Provider Name:		
Patient Name:				Specialty:		NPI:
Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female			Office Phone:		Office Fax:
Street Address:				Office Street Address:		
City:	State:	Zip:		City:	State:	Zip:
Patient ID:	R			Physician Signature:		
PHYSICIAN COMPLETES						

Sepiience (sepiapterin)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its entirety for processing

Is this request for brand or generic? Brand Generic

- Does the patient have a diagnosis of phenylketonuria (PKU)? Yes No
- Is the patient currently on a phenylalanine-restricted diet? Yes No
- Will this medication be used in combination with Palynziq (pegvaliase-pqpz) or Kuvan/Javygtor (sapropterin)? Yes* No
*If YES, please specify the medication: _____
- Has the patient been on this medication continuously for the last **2 months** excluding samples? **Please select answer below:**
 - NO** – this is **INITIATION** of therapy, please answer the following questions:
 - Does the prescriber agree to monitor phenylalanine levels? Yes No
 - Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to generic Kuvan (sapropterin)? Yes No
 - YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
 - Has there been a reduction in phenylalanine levels from baseline by 30% or greater? Yes No