Kuvan ® (sapropterin) Prior Authorization Form

Incomplete forms will not be reviewed

Maryland Medicaid Pharmacy Program
Fax: (866) 440-9345
Phone: (833) 325-0105

Date: _____

Patient Information

Name: _____ DOB: _____

Medicaid Assistance Number: _____ ❑ M ❑ F Height: _____ Weight: _____

Prescriber Information

Name: _____ NPI: _____

Contact Person for this Request:

Name: _____ Phone: _____ Fax: _____

Diagnosis: ❑ Classical PKU ❑ Other: _____

Prescription Information:

Dose: ❑ 5mg/kg/d ❑ 10mg/kg/d ❑ 15mg/kg/d ❑ 20mg/kg/d ❑ Other: _____

Strength: _____ mg ❑ Tablet ❑ Powder

Direction: _____

Clinical Information:

Any residual enzyme activity? ❑ Yes ❑ No ❑ Unknown Phenylalanine (Phe) level: _____

Is Patient receiving a phenylalanine-free nutritional supplement? ❑ Yes ❑No

If yes, please specify: _____

Is patient compliant with a phenylalanine restricted diet? _____

❑ Submit the most recent progress note and pertinent lab/test results for both initial and renewal requests. Objective clinical benefits should be evident in the note for any renewal request.

❑ Submit molecular genetics lab results if available with history of Phe levels obtained over the past 3 months prior to treatment.

Phe level: Month 1: _____ Month 2: _____ Month 3: _____

I attest that

❑ Patient's lab test results and clinical data will be evaluated and monitored.

❑ The requested medication is not part of a clinical trial and that the benefits of the treatment outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge.

MDH and prescriber acknowledge and agree that this request may be executed by electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original signature.

Prescriber's Signature_____ Date_____