Orfadin® and Nityr® (nitisinone) Prior Authorization Form

Incomplete forms will not be reviewed

Maryland Medicaid Pharmacy Program
Fax: (410) 333-5398
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:** Hereditary Tyrosinemia Type 1 (HT-1) ❑ Other_____

Prescription Information

❑ Initial request ❑ Renewal request

❑ Orfadin capsule: _____mg ❑ Suspension (4mg/ml) ❑ Nityr tablet: _____mg

Direction: _____

Quantity: _____ Refills: _____

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

I attest that

❑ Dietitian and/or metabolic specialist is part of care team to create dietary restrictions of tyrosine and phenylalanine, the patient is adherent to dietary restrictions, and dietary restriction alone is not sufficient to maintain urine/serum tyrosine and phenylalanine below recommended levels.

❑ 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_____