AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
Sapropterin Dihydrochloride (Kuvan)

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
Provider NPI:	Prescriber name:		Phone:
Prescriber address:			Fax:
Pharmacy name:			
Address:			Phone:
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.			
Pharmacy NPI:		Pharmacy fax:	NDC:

Prior authorization is required for sapropterin (Kuvan). Requests for doses above the FDA-approved dose will not be considered. Initial requests will be considered for patients when the following criteria are met:

1. Patient has a diagnosis of phenylketonuria (PKU); and
2. Patient is on a phenylalanine (Phe) restricted diet prior to therapy and will continue throughout therapy; and
3. Patient has a baseline blood Phe level ≥ 360 micromol/L while following a Phe restricted diet, obtained within two weeks of initiation of sapropterin therapy (attach lab results); and
4. Patient's current weight is provided; and
5. Request is for an FDA-approved starting dose (10mg/kg/day for patients 1 month to 6 years and 10-20mg/kg/day for patients 7 years and older); and
6. Blood Phe levels will be measured after one week of therapy and at least one other time during the first month of therapy.

Initial requests will be considered for one month to assess response to therapy. Continuation of therapy will be considered when the following criteria are met:

1. Patient's current weight is provided; and
2. Patient continues on a phenylalanine (Phe) restricted diet; and
3. For patients initiated at a dose of 10mg/kg/day and the blood Phe level did not decrease from baseline, dose may be increased to 20mg/kg/day. Approval will be given for one month to assess response to therapy.
4. For patients initiated at a dose of 20mg/kg/day or those increased to this dose after one month of therapy at 10mg/kg/day, an updated blood Phe level must be provided documenting response to therapy, defined as at least a 30 percent reduction in blood Phe level. If blood Phe level does not decrease after one month at 20mg/kg/day, the patient is considered a non-responder and no further requests will be approved.
5. Maintenance dose requests will be considered for patients that have responded to therapy, based on the above criteria, at six month intervals. Documentation of compliance to diet and updated blood Phe levels documenting continued response to therapy are required for further consideration.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

Non-Preferred

☐ Kuvan

Strength: Dosage instructions: Quantity: Days supply:

Diagnosis:

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Initial Requests:

Has patient been on a Phe restricted diet prior to sapropterin therapy? ☐ Yes ☐ No

If yes, provide baseline blood Phe level while following the Phe restricted diet (attach results obtained within two weeks of initiation of sapropterin therapy): Date obtained:

If yes, will patient continue on Phe restricted diet throughout sapropterin therapy? ☐ Yes ☐ No

Patient's weight (kg): Date obtained:

Will blood Phe levels be measured after one week of therapy and at least one other time during the first month of therapy?
☐ Yes ☐ No

Requests for Continuation of Therapy:

Patient's weight (kg): Date obtained:

Is patient currently on a Phe restricted diet? ☐ Yes ☐ No

Current blood Phe level (attach results): Date obtained:

☐ **For patients who initiated dose of 10mg/kg/day:**

Did patient experience at least a 30 percent reduction in Phe level from baseline?

☐ Yes ☐ No If no, is dose increase being requested? ☐ Yes ☐ No

☐ **For patients who initiated dose at or tapered dose to 20mg/kg/day:**

Did patient experience at least a 30 percent reduction in Phe level from baseline after one month of therapy at a dose of 20mg/kg/day? ☐ Yes ☐ No

Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste, and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.	
Prescriber signature: (Must match prescriber listed above.)	Date of submission:

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.