Please complete ALL information below and fax your request to 1-888-671-5285

Kuvan® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Phenylketonuria (PKU)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Will Kuvan be used in conjunction with a phenylalanine (Phe)-restricted diet? ❑ **Yes** ❑ **No**

Will the patient have Phe blood levels measured after 1 week of therapy and periodically for up to two months of therapy to determine response? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following questions:

Has the patient had an objective response to therapy, defined as a 30% or greater reduction in phenylalanine (Phe) blood levels from baseline? ❑ **Yes** ❑ **No**

Will Kuvan be used in conjunction with a phenylalanine (Phe)-restricted diet? ❑ **Yes** ❑ **No**

Will the patient continue to have blood Phe levels measured periodically during therapy? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.