



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

Kuvan® Prior Authorization Request Form

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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:
<input type="checkbox"/> Check if generic substitution is acceptable	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

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.

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