

PRIOR-AUTHORIZATION OF KUVAN™ (Sapropterin)
Maryland Pharmacy Program
 Telephone Number 800-932-3918 Fax form to: 866-440-9345
(Incomplete forms will be returned)

Patient Information

Patient location: ___ Home; ___ Hospital ___ Clinic ___ Office Age: _____ Date of Birth: ____/____/____
 Patient Name: _____ MA # _____
 Address: _____
 Tel.#:(_____) _____ - _____
 Is Patient receiving a phenylalanine free nutritional supplement? Yes No
 List name of metabolic product: _____
 Is patient compliant with a phenylalanine restricted diet? Yes No
 Diagnoses: Classical PKU ; Variant PKU due to cofactor deficiency Other: _____
 Any residual enzyme activity? Yes; No; Unknown; PAH level: _____ mg/dL or _____ micromol/L
 Submit molecular genetics lab results if available with history of phenylalanine(phe) levels obtained over the past 3 months prior to treatment along with a copy of Patient's medical history. Submit Blood phe levels with each prior-auth request.
 Average Baseline or Baseline Phe level: _____ micromoles/Liter-Date of test: _____;
 Follow-Up Phe levels: Initiation of Therapy Continuation of Therapy - Date of last visit: _____
 At Wk 1: _____ micromoles/L-Date of test: _____; Dosage taken: _____ mg/kg/d
 At Wk 2: _____ micromoles/L-Date of test: _____; Dosage taken: _____ mg/kg/d
 At Wk 3: _____ micromoles/L- Date of test: _____; Dosage taken: _____ mg/kg/d
 At Wk 4: _____ micromoles/L-Date of test: _____; Dosage taken: _____ mg/kg/d
 Side-effects/Response to Kuvan : _____

Prescriber Information

Is Kuvan™ prescribed as part of a clinical study? Yes No
 By regulation, sponsors for the clinical study is responsible for providing the study drug.
 I certify that Patient is **not** enrolled in any study involving the requested drug. I will be supervising the patient's treatment accordingly. Supporting medical documentation is kept on file in the patient's medical record.
 _____, M.D. Prescriber's Name: _____ Date: _____
 (Prescriber's signature) Tel# (_____) - _____ - _____ Fax# (_____) - _____ - _____
 Specialty : _____ DEA# _____; NPI #: _____

Prescription Information

Drug/Strength/dosage prescribed: _____
 Dosage prescribed: 5mg/kg/d 10mg/kg/d 15mg/kg/d 20mg/kg/d
 Based on Body Weight: _____ Kg or _____ lbs Date of measurement: _____
 Recommended start dose of 10mg/kg/day initially for 30 days before an increase to the max dose of 20mg/kg/d for another 30 days; Dosage may be adjusted upward or downward thereafter. Max dose allowed: 20mg/kg/d

FOR INTERNAL USE

Approved: Denied: Date: _____ Reviewer's Initials _____
 Reasons for denial: _____

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