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: _____
(Presscriber'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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