



Send completed form to:
 Peach State Health Plan Pharmacy Department
Fax: 1-866-374-1579

Kuvan

Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copay or medication delivery; please contact Peach State Health Plan at **1-800-514-0083 option # 2.**

Patient Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Physician Office Address: _____

1. What drug is being prescribed? Kuvan Dose: _____ Frequency: _____ Other _____
2. Will Kuvan dose be maintained in the range of 5 to 20 mg/kg/day? Yes No
3. What is the diagnosis? Phenylketonuria (PKU) Other _____
4. **What is the ICD9?** _____
5. What is the patient's age? _____ **years**
6. Will Kuvan be used in conjunction with a phenylalanine-restricted diet? Yes No
7. Document patient's **BASELINE** blood phenylalanine (Phe) level: _____mg/dL
8. Has the patient previously received Kuvan therapy (i.e. completed a therapeutic trial of Kuvan)?
 *If Yes, skip to # 11 Yes No
9. Will the patient's blood Phe level be checked after 1 week and periodically up to 1 month?
 Yes No
10. Will Kuvan treatment be discontinued if the patient's blood Phe levels do not decrease after 1 month?
 Yes No

Only answer below if patient has previously completed a therapeutic trial with Kuvan

11. Document patient's **CURRENT** blood phenylalanine (Phe) level: _____mg/dL
12. Is this the patient's first treatment with Kuvan *after a therapeutic trial*? Yes No
13. What was the patient's reduction in blood Phe level during therapeutic trial with Kuvan?
 Greater than or equal to 30% reduction in Phe level No baseline and/or current blood Phe level
 Less than 30% reduction in Phe level
14. **ATTACH documentation of efficacy.**

****NOTE: We can NOT make a decision without a copy of the results - Thank You****

Information given on this form is accurate as of this date:

X _____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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