Palynziq

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. 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 to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

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

1. What is the diagnosis?
   ❑ Phenylketonuria (PKU)
   ❑ Other _____
2. What is the ICD-10 code? _____
3. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #5*
4. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? ❑ Yes ❑ No ❑ Unknown
5. The preferred product for your patient's health plan is generic sapropterin dihydrochloride. Can the patient's treatment be switched to the preferred product? ***If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.*** ❑ Yes ❑ No
6. Does the patient have a documented inadequate response or intolerable adverse event to treatment with sapropterin dihydrochloride? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) and skip to #8.***
   ❑ Yes ❑ No
7. Does the patient have a documented phenylalanine hydroxylase (PAH) deleterious genotype with two null-alleles? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No
8. Was the diagnosis confirmed by a blood phenylalanine (Phe) concentration greater than 600 micromol/L or a genetic test? ***ACTION REQUIRED: If Yes, please attach blood phenylalanine (Phe) concentration test result or genetic test result.*** ❑ Yes ❑ No

Complete the following section based on type of request.

Section A: Initial Request

9. Prior to initiation of the requested medication, what was the patient's baseline blood phenylalanine (Phe) concentration? _____ micromol/L ❑ No baseline blood Phe concentration

Send completed form to: Case Review Unit CVS Caremark Prior Authorization Fax: 1-866-249-6155

10. Will the requested medication be initiated in a patient currently receiving Kuvan for phenylketonuria (PKU)?
    ❑ Yes ❑ No *If No, no further questions.*

11. Will Kuvan be discontinued after an appropriate period of overlap? ❑ Yes ❑ No

Section B: Request for Continuation of Therapy

12. Has the patient achieved a clinical response as evidenced by a blood phenylalanine (Phe) concentration of less than or equal to 600 micromol/L? *If Yes, skip to #15* ❑ Yes ❑ No

13. Has the patient been titrated to the maximum allowed dose of 60 mg once daily?
    ❑ Yes ❑ No *If No, skip to #15*

14. Has the patient received continuous treatment with the requested medication for at least 16 weeks at the maximum allowed dose of 60 mg once daily? ❑ Yes ❑ No

15. Will the requested medication be used concomitantly with Kuvan for phenylketonuria? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

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

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