

# Kuvan™ (sapropterin dihydrochloride)



An Independent Licensee of the Blue Cross and Blue Shield Association

## Prior Authorization Request (Physician to Complete)

Visit [www.wellmark.com](http://www.wellmark.com) for the Wellmark Drug List for current medication tier levels and updated PA Forms

### Facsimile Transmittal Sheet

Date: \_\_\_/\_\_\_/\_\_\_

To: Wellmark Pharmacy Services

From (Prescriber's Name): \_\_\_\_\_

Fax Number: (866) 884-4345

Prescriber's DEA Number: \_\_\_\_\_

Phone Number: (800) 600-8065

Prescriber's Phone Number: \_\_\_\_\_

Prescriber's Specialty: \_\_\_\_\_ Prescriber's Fax Number: \_\_\_\_\_

Prescriber's Office Address: \_\_\_\_\_  
Street Suite # City State Zip

Patient Name: \_\_\_\_\_

Patient ID: \_\_\_\_\_ Patient DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Please answer the following questions and fax this form back to (866) 884-4345. All fields are REQUIRED.

### For INITIAL Therapy Requests:

1. Please provide the diagnosis this therapy has been prescribed for: \_\_\_\_\_  
\_\_\_\_\_

ICD-9 Code: \_\_\_\_\_

2. Is the patient being treated with a phenylalanine (Phe)-restricted diet?  Yes  No

3. What is the patients phenylalanine level? \_\_\_\_\_  $\mu\text{mol/L}$

4. What is the patients weight (in kg) \_\_\_\_\_ kg

5. Drug Strength: \_\_\_\_\_ mg Quantity/30 days: \_\_\_\_\_ units

Directions: \_\_\_\_\_

### For CONTINUATION of Therapy Requests:

1. Has the patient demonstrated and maintained at least a 30 percent reduction in phenylalanine (Phe) levels from baseline after 30 days of treatment at a dosage level within the range of 5-20 mg/kg/day?  Yes  No

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

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