PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

9/9/2026	<%PANumber%>

Prior Authorization

Internal Use Only

JOHNS HOPKINS HEALTH PLANS

Palynziq - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**.
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Palynziq - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Palynziq (pegvaliase-pqpz)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is the requested medication being prescribed for any indications or uses that are not Food and Drug Administration (FDA)-approved, or guideline-supported?	Y N
[If yes, no further questions.]	

2. Is the patient less than 12 years of age?	Y N
[If yes, no further questions.]	
3. Will the requested medication be used concurrently with sapropterin products (i.e., Kuvan, Javygtor, Zelvysia, generic sapropterin) or Sephience (sepiapterin)?	Y N
[If yes, no further questions.]	
4. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)?	Y N
NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.	
[If no, skip to question 8.]	
5. Is there documentation showing that the patient has had a beneficial response to treatment?	Y N
NOTE: Submission of medical records is required	
[If no, no further questions.]	
6. Is there documentation submitted showing that the patient achieved a blood phenylalanine concentration of less than or equal to 600 micromol/L?	Y N
NOTE: Submission of medical records is required	
[If yes, no further questions.]	
7. Is there documentation submitted showing that the patient has a blood phenylalanine concentration less than or equal to 600 micromol/L AND meets ONE of the following: A) Patient has not been titrated to the maximum allowed dose of 60 mg once daily, OR B) Patient has received less than 16 weeks of continuous treatment at the maximum allowed dose of 60 mg once daily?	Y N
NOTE: Submission of medical records is required	
[No further questions.]	
8. Is there documentation confirming a diagnosis of phenylketonuria?	Y N
NOTE: Documentation must be submitted.	
[If no, no further questions.]	
9. Does the patient have a clinical diagnosis of hyperphenylalaninemia (HPA) documented by past medical history of at least 2 blood phenylalanine measurements greater than or equal to 600 mciromol/L?	Y N
NOTE: Documentation must be submitted.	
[If no, no further questions.]	
10. Has the patient had a trial and inadequate response, or intolerance to sapropterin in combination with a phenylalanine (Phe)-restricted diet?	Y N
NOTE: Documentation must be submitted.	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date