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

Sapropterin Products - 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 Sapropterin Products - Priority Partners MCO.

Drug Name
(specify drug) _____

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. Will the requested medication be used for any indications that are not Food and Drug Administration (FDA)-approved or guideline-supported? Y N

[If yes, no further questions.]

2. Will the requested medication be used concurrently with Sephience (sepiapterin) or Palynziq (pegvaliase-pqpz)?	Y N
[If yes, no further questions.]	
3. Is the patient 1 month of age or older?	Y N
[If no, 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 6.]	
5. Is the patient experiencing a beneficial response to treatment, as evidenced by at least ONE of the following: A) Achieving or maintaining a 30% decrease in phenylalanine levels from baseline, B) Phenylalanine levels are in an acceptable range (less than 360 micromol/L), or C) Patient has had an improvement in neuropsychiatric symptoms?	Y N
NOTE: Submission of medical records is required.	
[No further questions.]	
6. Does the patient have a diagnosis of phenylketonuria (PKU)?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
7. Does the patient have a baseline phenylalanine level greater than or equal to 360 micromol/L (6 mg/dL) with dietary interventions alone?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
8. Will the requested medication be used in combination with a phenylalanine (Phe)-restricted diet?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
9. Is the request for generic sapropterin?	Y N
NOTE: Submission of medical records is required.	
[If yes, no further questions.]	
10. Is the request for Javygtor, Kuvan, or Zelvysia?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
11. Has the patient tried and had an inadequate response to generic sapropterin?	Y N
NOTE: Submission of medical records is required.	

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