Prior Authorization Request Form for
pegvaliase-pqpz (**Palynziq**)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #: _____

Step 2 Please complete the clinical assessment:

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Palynziq*	☐ Yes (subject to verification) Proceed to question **8**	☐ No Proceed to question **2**
2. Is the patient 18 years of age or older?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Does the patient have uncontrolled blood phenylalanine concentrations greater than 600 micromol/L on at least one existing treatment modality (e.g., restriction of dietary phenylalanine and protein intake, or prior treatment with Kuvan [sapropterin dihydrochloride tablets and powder for oral solution])?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the requested medication being prescribed by or in consultation with a metabolic disease specialist (or specialist who focuses on the treatment of metabolic diseases)?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the provider acknowledge and has educated the patient on the risk of anaphylaxis?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Does the patient have a prescription for self-administered SQ epinephrine?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

7. Is the patient using Palynziq concomitantly with Kuvan?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
8. Is the patient's blood phenylalanine concentration less than or equal to 600 micromol/L?	☐ Yes Proceed to question **10**	☐ No Proceed to question **9**
9. Has the patient has achieved a greater than or equal to 20% reduction in blood phenylalanine concentration from pre-treatment baseline (i.e., blood phenylalanine concentration before starting Palynziq therapy)?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Is the patient using Palynziq concomitantly with Kuvan?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[31 July 2019]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: