TRICARE Prior Authorization Request Form for
sepiapterin (Sephience)



JOHNS HOPKINS
HEALTH PLANS

7231 Parkway Drive, Suite 100
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Fax completed form and applicable progress notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

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.

Prior authorization expires in 6 months. For renewal of therapy an initial TRICARE PA approval is required. Renewals will be approved for one year.

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 the requested medication.*	☐ Yes (subject to verification) Proceed to question **9**	☐ No Proceed to question **2**
2. Is the patient 1 month of age or older?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is the requested medication being prescribed by or in consultation with a metabolic disease specialist?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. What is the indication or diagnosis?	☐ Phenylketonuria (PKU) with hyperphenylalaninemia – Proceed to question **5** ☐ Other diagnosis – **STOP – Coverage not approved**	
5. Does the patient have uncontrolled blood phenylalanine concentrations GREATER THAN 360 micromol/L while on AT LEAST ONE existing treatment modality (for example, restriction of dietary phenylalanine)?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Is the patient receiving concomitant pharmacologic treatment for Phenylketonuria (PKU) (for example, sapropterin, pegvaliase)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **7**

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7. Will the requested medication be used in conjunction with a phenylalanine restricted diet?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Has the patient had an inadequate response, adverse reaction, or contraindication to generic sapropterin up to maximally tolerated dose?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
9. Has the patient's disease severity improved and stabilized to warrant continued therapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

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

_____ _____
Prescriber Signature Date

[15 July 2026]

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