Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Kuvan
(sapropterin)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested: ICD10:
☐ Kuvan 100mg tablet
☐ Kuvan 100mg powder for oral solution
☐ Kuvan 500mg powder for oral solution

Directions for user: Duration of therapy:

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Clinical Information:
****This drug requires supportive documentation (chart notes, genetic test/lab results, etc) be attached with this request****

Is this for new start of therapy or continuation of therapy? If your patient has already begun treatment with drug samples of this drug, please choose "new start of therapy". ☐ new start ☐ continued therapy

(if continued therapy) Which of the following applies to your patient?
☐ blood phenylalanine levels were reduced by 20% or more concentration from pre-treatment baseline
☐ blood phenylalanine levels are being maintained within an acceptable range (120-360 micromol/L)
☐ neither of the above

(new start) Is your patient currently being treated with Palynziq?
☐ No, not currently - OR - Yes, but the drug will be stopped when stabilized on Kuvan
☐ Yes, and the patient will continue to use this drug with Kuvan
☐ Unknown

(if continued therapy) Is/Will your patient be taking Palynziq with Kuvan? ☐ Yes ☐ No
(Does your patient have a diagnosis of phenylketonuria (PKU)? Please include supportive documentation of this diagnosis.
☐ Yes ☐ No, (please explain):

Is your patient's diagnosis documented by either of the following? Please provide supportive documentation/genetic report.
☐ plasma phenylalanine concentration persistently above 120 micromol/L (2 mg/dL) AND altered ratio of phenylalanine to tyrosine in the untreated state with normal BH4 cofactor metabolism
☐ genetic testing
☐ neither of the above

(if genetic testing) Is there documentation that your patient has alterations of BOTH copies (biallelic) of the PAH (phenylalanine hydroxylase) gene? Please provide genetic testing results. ☐ Yes ☐ No

Is your patient following a PKU diet (phenylalanine restricted)? ☐ Yes ☐ No

Additional Pertinent Information: *(including disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently):*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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