

**Complete Patient and Physician information (PLEASE PRINT)**

STEP 1	Member Name:	Physician Name:
	Address:	Address:
	Member ID:	Phone #:
	Member DOB:	Fax #:

**If Applicable:** Pharmacy Name: \_\_\_\_\_  
Pharmacy Phone: \_\_\_\_\_

**Complete the Clinical Assessment:**

**Please attach all relevant medical records and test results**

STEP 2	Diagnosis	<input type="checkbox"/> Hyperphenylalaninemia Phe level: _____ -(approved only when Phe >10mg/dl)	<input type="checkbox"/> Other _____ (clinical notes related to diagnosis required)
	Clinical Considerations	<input type="checkbox"/> Patient must be refractory to treatment with a Phe-restricted diet (please attach notes). <input type="checkbox"/> Tetrahydrobiopterin (BH4) responsiveness (please attach notes): -Initial approval will be limited to <b>2 months</b> in order to assess response to therapy. -Subsequent approvals will be limited to 12 months and REQUIRE: 1. Documentation of treatment success -Success = $\geq 30\%$ ↓ Phe level	
	Physician Specialty	<b>Patient must be under the care of a Metabolic Disease Specialist</b>	
	Supporting Documentation Included <input type="checkbox"/>	Diagnosis: ICD-9 Code #/ Description (required):  Please attach a copy of the prescription or provide ALL of the information below: Kuvan® (sapropterin) Strength _____ Sig _____ Qty _____ Refills _____	

Incomplete forms will not be processed.

**I certify that the above is correct and accurate to the best of my knowledge (please sign and date).**

STEP 3 \_\_\_\_\_  
 Prescriber Signature \_\_\_\_\_ Date \_\_\_\_\_

STEP 4 **Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:**  
**970-248-5034**

Pharmacy Technician initials \_\_\_\_\_ Date Initiated \_\_\_\_\_

**Confidentiality Notice:**

This facsimile transmission (and/or documents accompanying it) may contain confidential information. This information is intended only for the use of the individual(s) named above. If you have received this transmission in error, or cannot identify the recipient for distribution purposes, please notify us immediately at 970-244-7760. Plans underwritten by Rocky Mountain HMO or Rocky Mountain HealthCare Options. 03/18/09