

Complete Patient and Physician information (PLEASE PRINT)

STEP
1

Member Name:	Physician Name:
Address:	Address:
Member ID:	Phone #:
Member DOB:	Fax #:
	Tax ID or NPI #:

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 (HPA)	<input type="checkbox"/> Other (please attach notes)
Clinical Considerations	<input type="checkbox"/> Tetrahydrobiopterin (BH4) responsiveness (please attach notes)	<ul style="list-style-type: none"> For Medicare members, the only clinical consideration required is BH4 responsiveness For Medicare members, all approvals will be for 12 months
	<input type="checkbox"/> Patient must be refractory to treatment with a Phe-restricted diet (please attach notes)	
	Phe level: _____ -(approved only when Phe >10mg/dl)	
	<ul style="list-style-type: none"> Initial approval will be limited to 2 months in order to assess response to therapy. Subsequent 12 month approvals will REQUIRE: <ul style="list-style-type: none"> Documentation of treatment success. <i>Success = ≥30% ↓ Phe level</i> 	
Physician Specialty	<input type="checkbox"/> Metabolic Disease Specialist <input type="checkbox"/> Other specialty:	
	• There is no physician specialty requirement for Medicare members	
Supporting Documentation Included <input type="checkbox"/>	Diagnosis: ICD-9/10 Code #/ Description / J Code (required):	
	Please attach a copy of the prescription or provide ALL of the information below: Kuvan® (sapropterin)	
	Strength _____	Sig _____
	Qty _____	Refills _____
<p>We will not process incomplete forms. If we do not receive the completed form & all relevant medical records & test results within 10 calendar days of this request, it will be denied.</p>		

STEP
3

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

Prescriber Signature

Date

STEP
4

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

Name of Person filling out form: _____

Pharmacy Technician initials _____ Date Initiated _____

Confidentiality Notice:

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