health information designs

Phenylketonuria Agents Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for a phenylketonuria agent must meet the following criteria:

- **Patient must have hyperphenalaninemia.**
- **Patient must be following a PHE restricted diet.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name		**Recipient Date of Birth**	Recipient Medicaid ID Number	
Prescriber Name				
Prescriber NPI		Telephone Number	Fax Number	
Address		City	State	Zip Code
Requested Drug and Dosage: □ KUVAN	**PHE level:**	**Diagnosis for this Request:**	**Patient's weight:**	

Has the patient been known to have two null mutations in TRANS?	□ YES	□ NO
Are baseline PHE levels attached?	□ YES	□ NO
Is patient of child-bearing potential?	□ YES	□ NO
Is this a renewal request?	□ YES	□ NO
Has the patient been compliant with diet and medications for past 6 months?	□ YES	□ NO

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #