Physician's Prior Authorization Questionnaire for Kuvan™

PATIENT'S NAME: ____________________ **ID#:** _______________ **DOB:** ______

Patient Address: ____

Kuvan™ is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the patient's diagnosis (no codes please)? _____________________________________
2. Does the patient have tetrahydrobiopterin-responsive PKU? ____Yes ____No
3. Is the patient following a PKU restricted diet? ____Yes ____No
4. What is the patient's current weight in kilograms? _____________________________________
5. What is the patient's baseline Phenylalanine level (prior to the initiation of Kuvan™)? ____________
6. What was the date of the baseline Phenylalanine level? _________________________________
7. Is the patient currently on Kuvan™? ____Yes ____No

   If yes:

   What is the current dose in mg/kg? ____

   What is the current level of Phenylalanine? ____

Response to Kuvan™ will be assessed after the first month of therapy. According to the clinical trials, patients are considered responsive if there is a decrease of $\geq 30\%$ in phenylalanine levels. Doses greater than 20mg/kg/day will not be approved. Please send copies of medical records and copies of Phenylalanine testing.

____ ________________________

Physician's Signature Date

____ ________________________

Please **Print** Name Fax Number

____ ________________________

Please **Print** Physician's Specialty Phone Number

Thank you for your assistance. Please contact Arkansas Blue Cross and Blue Shield at (501) 378-3392 if you have any questions or concerns. You also may fax your response(s) back to Arkansas Blue Cross at (501) 378-6980.

Sincerely,
Pharmacy Programs
Forms are also available online at http://usableadmin.abcbs.net/providers/PharmacyForms.aspx

Apr. 30, 08