PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Sodium phenylbutyrate/Buphenyl®

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product:
- ☐ Buphenyl powder for oral solution
- ☐ Buphenyl oral tablet
- ☐ sodium phenylbutyrate oral tablet
- ☐ sodium phenylbutyrate powder for oral solution

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Diagnosis of chronic hyperammonemia because of a urea cycle disorder
2. Patient's condition cannot be managed by dietary protein restriction
3. Patient's condition cannot be managed by amino acid supplementation

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

Priority Health Precertification Documentation

A. Does the patient have chronic hyperammonemia because of a urea cycle disorder?
☐ Yes ☐ No - rationale for use: _____

B. Was there an attempt to manage the patient's condition with dietary protein restriction?
☐ Yes ☐ No - rationale for use: _____

C. Was there an attempt to manage the patient's condition with amino acid supplementation?
☐ Yes ☐ No - rationale for use: _____

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 07/2016
Last reviewed 03/2020