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.

Penicillamine/Depen Titratabs®

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:
☐ Depen Titratab 250 mg tablet
☐ penicillamine 250 mg tablet

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 Wilson's disease (hepatolenticular degeneration).

2. Diagnosis of cystinuria and treatment with conservative measures (e.g. high fluid intake, sodium and protein restriction, urinary alkalization) were ineffective, not tolerated, or contraindicated. **We require clinical documentation showing the patient's trial and compliance with conservative measures faxed to Priority Health**

Note: Authorization for indications, dosing, or a route of administration 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 appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

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

New 03/2020
Updated 03/2020

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Wilson's disease
- ☐ Cystinuria
- ☐ *Other – the patient's condition is:* _____
  Rationale for use: _____

B. Has the patient been treated with conservative measures?

- ☐ Yes, *please list what has been tried*: _____
  _____
- ☐ No, *rationale*: _____

C. What was the patients urine output on the most recent urinalysis? _____

Additional information

Note: Quantity limit of 120 tablets per 30 days. For approval over the quantity limit, documentation proving conservative measures have continued in combination with Depen Titratabs or penicillamine 250 mg oral tablet, and that member has been compliant with these measures must be faxed to Priority Health.

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

New 03/2020
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