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.

Orfadin® (nitisinone) Capsule or Suspension

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

Drug product:
- ☐ Orfadin 2 mg capsule
- ☐ Orfadin 5 mg capsule
- ☐ Orfadin 10 mg capsule
- ☐ Orfadin 4 mg/mL suspension

Start date (or date of next dose): ______________

Date of last dose (if applicable): ______________

Dosing frequency: ______________

Drug cost information

The wholesale acquisition cost for one bottle of sixty 10 mg capsules is $27,247.

Precertification Requirements

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

1. Must have a diagnosis of hereditary tyrosinemia type 1 (HT-1)
2. Orfadin must be used in conjunction with dietary restriction of tyrosine and phenylalanine
3. Plasma tyrosine level must be less than 500 micromol/L
4. Orfadin suspension is limited to patients that are 24 months old or younger

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. What condition is this drug being requested for?

☐ Hereditary tyrosinemia type 1 (HT-1)

☐ *Other – the patient's condition is:* ______________________

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 07/2016

Last reviewed 03/2018

B. Is the patient on a diet restricted in tyrosine and phenylalanine?
☐ Yes ☐ No

C. Please provide the most recent plasma tyrosine level?

Plasma tyrosine: _______________micromol/L

D. Please provide the patient's most recent weight?

Weight: ________________ kg / lbs (circle one)

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