PriorityHealth

Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**
This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

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: ____________________

Precertification Requirements

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

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

Medically accepted indication

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor.)

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 07/2017

PriorityHealth

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:* ____________________

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)

Priority Health Medicare exception request

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Orfadin likely be the most effective option for this patient?

☐ No
☐ Yes, because:____________________

If the patient is currently using Orfadin, would changing the patient's current regimen likely result in adverse effects for the patient?

☐ No
☐ Yes, because:____________________

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 07/2017