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.

Trientine (generic Syprine®)

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: ☐ Trientine 250 mg capsule

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dose: _____

Frequency: _____

Precertification Requirements

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

1. Documentation of a diagnosis of Wilson's disease when established by or in consultation with a specialist in gastroenterology; AND
2. Treatment with penicillamine is not tolerated or is contraindicated.

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?

☐ Wilson's disease

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

Rationale for use: _____

B. Does patient have a contraindication to penicillamine?

☐ Yes, *please describe*: _____

☐ No

C. Has the patient tried penicillamine but could not tolerate?

☐ Yes, *please explain*: _____

☐ No

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

No changes made since 03/2017
Last reviewed 03/2018