Orfadin Susp (nitisinone)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTER (if different than prescriber):	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ **YES** (if yes, complete below) ☐ **NO**		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Hypertyrosinemia-1(HT1) ☐ Alkaptonuria(AKU) ☐ Other diagnosis: _____ ICD-10 Code(s):	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Is patient going to be using drug in combination with a clinical trial? ☐ **Yes** ☐ **No**

Is patient a pediatric patient under the age of 16, AND unable to swallow tablets or capsules? ☐ **Yes** ☐ **No**

Is patient 16 years of age or older, AND unable to swallow tablets or capsules and/or has enteral feedings? ☐ **Yes** ☐ **No Please submit documentation.**

<u>For diagnosis of Hypertyrosinemia-1(HT-1), answer the following:</u>
Does patient have the presence of succinylacetone in the urine or plasma to validate the diagnosis? ☐ **Yes** ☐ **No Please submit documentation.**

Does patient have genetic confirmation of HT-1(documentation required)? ☐ **Yes** ☐ **No Please submit documentation.**

Is patient adhering to a tyrosine and phenylalanine low diet? ☐ **Yes** ☐ **No**

<u>For diagnosis of Alkaptonuria(AKU), answer the following</u>:
Does patient have presence of homogentisic acid(HGA) in their urine or plasma to validate the diagnosis? ☐ **Yes** ☐ **No Please submit documentation.**

Does patient have genetic confirmation of AKU? ☐ **Yes** ☐ **No Please submit documentation.**

Is patient adhering to a tyrosine and phenylalanine low diet? ☐ **Yes** ☐ **No**

Has the patient tried the generic nitisinone product? □ **Yes** □ **No**

Does patient have an absolute contraindication to the generic nitisinone? □ **Yes** □ **No** ***Please provide supporting chart notes.***

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If the patient has tried the authorized generic nitisinone and will not be continuing it, has a U.S. FDA MedWatch Voluntary Reporting Form for adverse drug reactions (FDA Form 3500) been filed with the FDA? □ **Yes** □ **No** ***Please submit a copy of the completed FDA 3500 form*.**

Renewal Request:

For diagnosis of HT-1, does patient continue to demonstrate a positive clinical response by showing a reduction in succinylacetone levels in the urine or plasma for HT-1? ☐ **Yes** ☐ **No Please submit documentation.**

For diagnosis of AKU, does patient continue to demonstrate a positive clinical response by showing a reduction in homogentisic acid(HGA) levels in their urine or plasma for AKU? ☐ **Yes** ☐ **No Please submit documentation.**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 877-228-7909