Prescriber Criteria Form

Sapropterin 2025 PA Fax 341-A v1 010125.docx
Kuvan, Javygtor (sapropterin dihydrochloride)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Sapropterin.

Drug Name (select from list of drugs shown):

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of phenylketonuria (PKU)? [If no, then no further questions.]	Yes ◯	No ◯
2	Has the patient completed a therapeutic trial with the requested drug? [If no, then skip to question 4.]	Yes ◯	No ◯
3	Has the patient experienced improvement (e.g., reduction in blood phenylalanine levels, improvement in neuropsychiatric symptoms) after completing a therapeutic trial? [No further questions.]	Yes ◯	No ◯
4	Does the patient have pretreatment (including before dietary management) phenylalanine (Phe) level greater than 6 milligrams per deciliter (360 micromole per liter)?	Yes ◯	No ◯

Comments: _____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____