

**KUVAN® (SAPROPTERIN)  
 PREAUTHORIZATION REQUEST  
 PHYSICIAN FAX FORM**



**ONLY the prescriber may complete and fax this form.**

**The following documentation is REQUIRED.** Incomplete forms will be returned for additional information. For formulary information and to download additional forms, please visit [www.bcbsil.com](http://www.bcbsil.com)

**Today's Date:** \_\_\_\_\_

**PATIENT INFORMATION**

|                       |       |                  |                    |
|-----------------------|-------|------------------|--------------------|
| Patient Name (First): | Last: | M:               | DOB (mm/dd/yyyy):  |
| Patient Address:      |       | City, State, Zip | Patient Telephone: |

**INSURANCE INFORMATION**

|                 |               |
|-----------------|---------------|
| BCBS ID Number: | Group Number: |
|-----------------|---------------|

**PHYSICIAN/CLINIC INFORMATION**

|                   |                 |                 |               |
|-------------------|-----------------|-----------------|---------------|
| Prescriber Name:  | Physician NPI#: | Specialty:      | Contact Name: |
| Clinic Name:      |                 | Clinic Address: |               |
| City, State, Zip: |                 | Phone #:        | Secure Fax #: |

**PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST**

|  |                     |
|--|---------------------|
| Patient's Diagnosis - ICD-9 code plus description:   |                     |
| Medication Requested:  |                     |
| Dosing Schedule:   | Quantity per Month: |
| 1. Has/was a baseline blood phenylalanine (Phe) level measured? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Patient's blood Phe level _____ Date of blood Phe level _____  |                     |
| 2. Is the patient compliant with PKU dietary restrictions? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |                     |
| 3. Is the patient currently treated with Kuvan? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, when was treatment with Kuvan started? _____<br>If yes, what is current dose of Kuvan (mg/kg/day)? _____<br>If yes, what has been change in blood Phe level? _____ |                     |
| 4. Will the patient's diet be modified in any way during the initial 1-month or 2-month trial of Kuvan therapy? .... <input type="checkbox"/> Yes <input type="checkbox"/> No  |                     |
| 5. Is the prescriber a specialist with knowledge and expertise in metabolic disease or genetic diseases? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |                     |
| 6. Please list all reasons for selecting the requested <b>medication</b> for this patient. _____<br>_____<br>_____   |                     |

**Renewal Only**

7. Has the prescriber verified that the patient's diet was NOT modified in any way during the initial 1-month or 2-month trial of Kuvan therapy? .....  Yes  No

**Please fax or mail this form to:**  
 Blue Cross and Blue Shield of Illinois  
 c/o Prime Therapeutics LLC, Clinical Review Department  
 1305 Corporate Center Drive  
 Eagan, Minnesota 55121

**TOLL FREE**

**Fax: 877.480.8130 Phone: 800.285.9426**

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