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Fax Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization
Sepiapterin (Sephience)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone

Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.

Pharmacy NPI	Pharmacy fax	NDC

Prior authorization (PA) is required for sepiapterin (Sephience). Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and

2. Patient has a diagnosis of hyperphenylalaninemia (HPA) with sepiapterin-responsive phenylketonuria (PK); and

3. Patient is on a phenylalanine (Phe) restricted diet prior to therapy and will continue throughout therapy; an

4. Patient has a baseline blood Phe level ≥ 360 µmol/L while following a Phe restricted diet, obtained within 2 weeks of initiation of sepiapterin therapy (attach lab results); and

5. Patient's current weight in kg is provided; and

6. Blood Phe levels will be measured after 2 weeks of therapy and at least one more time before initial renewal; and

7. Is not prescribed concurrently with sapropterin (Kuvan) or pegvaliase-pqpz (Palynziq).

Initial requests will be considered for 2 months to assess response to therapy.

Continuation of therapy will be considered when the following criteria are met:

1. **Patient's current weight in kg is provided; and**
2. **Patient continues a Phe restricted diet; and**
3. **After an initial 2-month treatment, an updated blood Phe level must be provided documenting response to therapy, defined as at least a 30% reduction on blood Phe level. If blood Phe level does not decrease at maximum dose, the patient is considered a non-responder and no further requests will be approved; and**
4. **Patient continues to respond to therapy as demonstrated by a reduction in Phe blood levels since initiation of therapy; and**
5. **Is not prescribed concurrently with sapropterin (Kuvan) or pegvaliase-pqpz (Palynziq).**

Non-Preferred

☐ Sephience

Strength	Usage Instructions	Quantity	Day's Supply
_____	_____	_____	_____

Diagnosis: _____

Request for Prior Authorization

Sepiapterin (Sephience)

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Is patient on a phenylalanine (Phe) restricted diet prior to therapy and will continue throughout therapy?

- ❑ Yes
- ❑ No

Does patient have a baseline blood Phe level ≥ 360 µmol/L while following a Phe restricted diet, obtained within 2 weeks of initiation of sepiapterin therapy?

- ❑ Yes, attach results
- ❑ No

Patient's current weight in kg: _____ Date obtained: _____

Will blood Phe levels be measured after 2 weeks of therapy and at least one more time before initial renewal?

- ❑ Yes
- ❑ No

Will sepiapterin be prescribed concurrently with sapropterin (Kuvan) or pegvaliase-pqpz (Palynziq)?

- ❑ Yes
- ❑ No

Renewal Requests

Patient's current weight in kg: _____ Date obtained: _____

Is patient continuing a phenylalanine (Phe) restricted diet?

- ❑ Yes
- ❑ No

Provide updated blood Phe level documenting response to therapy of at least a 30% reduction in Phe level: Date obtained: _____

Does patient continue to respond to therapy as demonstrated by a reduction in Phe blood levels since initiation of therapy?

- ❑ Yes
- ❑ No

Is sepiapterin prescribed concurrently with sapropterin (Kuvan) or pegvaliase-pqpz (Palynziq)?

- ❑ Yes
- ❑ No

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization, the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary, by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*