

**Physician Request Form Kuvan™**

Fax to Keystone Mercy Pharmacy Services at **215-937-5018**, or to speak to a representative call **800-588-6767**. *Form must be completed for processing.*

Patient Name: \_\_\_\_\_

Patient ID#: \_\_\_\_\_

Address: \_\_\_\_\_

Apt # or Suite #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs = \_\_\_\_\_ Kg

Birth Date: \_\_\_\_\_

Physician Name: \_\_\_\_\_

NPI #: \_\_\_\_\_

Address: \_\_\_\_\_

Apt # or Suite #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

ICD-9 Diagnosis Code: \_\_\_\_\_

Sig (How Administered): \_\_\_\_\_

**A. For patients with a diagnosis of Phenylketonuria (PKU):**

- o Is this patient currently utilizing a Phe-restricted diet with Phe free medical products/foods? (please check)
  - Yes (if yes please attach any receipts or order forms that the patients has-failure to do so could result in a delay in any possible approvals)
  - No, then why \_\_\_\_\_
- o Dosage being prescribed for the patient. = \_\_\_\_\_ mg/kg/day  
 Patients weight \_\_\_\_\_ lbs or \_\_\_\_\_ kg = \_\_\_\_\_ mg/day

**Lab Results** (Please submit a copy of the most recent labs and/or complete the following - lab values should be within 30 days of request)

Date of Lab Results	Blood Phe Levels	Date of Lab Results	Blood Phe Levels
1.	1. Baseline results =	6.	6.
2.	2. 1 <sup>st</sup> result during the initial month of treatment =	7.	7.
3.	3. 2 <sup>nd</sup> result during the initial month of treatment =	8.	8.
4.	4.	9.	9.
5.	5.	10.	10.

**B. Diagnosis other than Phenylketonuria (PKU):**

- o Rationale for choosing this treatment, please include all applicable documentation \_\_\_\_\_

**IMPORTANT AUTHORIZATION INFORMATION:** Kuvan™ will only be authorized for a **ONE MONTH** duration for the **INITIAL AUTHORIZATION**. At that point, for any patient that requires an increase in dose of up to 20 mg/kg/day his/her second authorization will be for a **ONE MONTH** duration. Reauthorization will require that documentation of the patient's blood Phe level, the patient's weight, and documentation (e.g. receipts, order forms) supporting that the patient is utilizing a Phe restricted diet with Phe free medical products/foods be submitted with each request.