

Physician Request Form Kuvan™

Fax to PerformRx Pharmacy Services at **888-981-5202**, or to speak to a representative call **866-610-2774**. *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):

- 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 _____
- 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 st result during the initial month of treatment =	7.	7.
3.	3. 2 nd result during the initial month of treatment =	8.	8.
4.	4.	9.	9.
5.	5.	10.	10.

B. Diagnosis other than Phenylketonuria (PKU):

- 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.

