United Healthcare Community Plan

COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

PALYNZIQ™ (pegvaliase-pqpz)

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION

Palynziq™ – to receive an initial 16 weeks approval for this drug, complete the following questions.

1. Does the member have a diagnosis of phenylketonuria with uncontrolled blood phenylalanine concentrations greater than 600 micromol/L on existing management? **AND**
   ☐ Yes ☐ No
2. Is the member 12 years of age or older? **AND**
   ☐ Yes ☐ No
3. Must obtain baseline blood phenylalanine concentration before initiating treatment. Is the blood phenylalanine concentration greater than 600 micromol/L? **AND**
   ☐ Yes ☐ No
4. Will administer the initial dose under the supervision of a healthcare provider and train the member and/or caregiver on proper self-administration for future administration? **AND**
   ☐ Yes ☐ No
5. Palynziq™ is available only through a restricted program under a REMS called the Palynziq™ REMS. Is the prescriber certified with the Palynziq™ REMS program? **AND**
   ☐ Yes ☐ No
6. Is the member enrolled in the Palynziq™ REMS program and educated on the risks of anaphylaxis? **AND**
   ☐ Yes ☐ No
7. The member MUST have a prescription for auto-injectable epinephrine.
   ☐ Yes ☐ No

Renewals: Approve for one (1) year if member maintains blood phenylalanine concentration reductions of 20% below baseline measurements.

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the SA process.
Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

Fax this form to 1-866-940-7328

Pharmacy PA Call Center 1-800-310-6826