



MEDICAID / CHIP
PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Palynziq - Non-PDL

Phone: 866-841-7659

Fax back to: 866-240-3712

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:	Prescriber Name:	
Member ID Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Phone Number:	NPI:	PA PROMISe ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):	
Drug Name:	Strength:	
Quantity:	Refills:	
Directions:		
Diagnosis Code:	Diagnosis:	
<i>Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..</i>		

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is the request for a reauthorization of Palynziq? If YES, go to 13. If NO, go to 2.

Yes

No

Q2. Is the patient 12 years of age or older?

Yes

No

Q3. Is Palynziq being prescribed by or in consultation with a metabolic diseases specialist or a provider who specializes in the treatment of PKU?

Yes

No

Q4. Does the patient have a diagnosis of uncontrolled phenylketonuria confirmed by baseline blood phenylalanine concentrations greater than 600 micromol/L? Chart notes documenting diagnosis AND baseline labs must be attached.

Yes

No

Q5. Has the patient tried non-pharmacological treatment options (such as restriction of dietary phenylalanine intake)? Notes must be attached showing the patient has tried and failed dietary restriction in consultation with a nutritionist.



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Yes

No

Q6. Does the patient have a documented trial and failure of or contraindication/intolerance to sapropterin dihydrochloride (sapropterin dihydrochloride will require Prior Authorization)? Documentation of contraindication/intolerance or trial and failure (at a dose of 20mg/kg for at least 1 month of therapy) must be attached.

Yes

No

Q7. Has auto-injectable epinephrine been prescribed and has the patient been instructed on proper use and to have it on them at all times? Chart notes documenting that auto-injector epinephrine has been prescribed to the patient and counseling has been done must be attached.

Yes

No

Q8. Is there documentation that the initial dose will be administered under the supervision of a healthcare provider?

Yes

No

Q9. Is there documentation showing Palynziq will be initiated at the recommended induction dose?

Yes

No

Q10. Is there documentation showing Palynziq will be titrated over at least 5 weeks after completing the 4-week induction period to an effective maintenance dosage?

Yes

No

Q11. Will the patient be taking a stable maintenance dose of Palynziq concomitantly with sapropterin or sepiapterin (Sephience)? Note: Concomitant use with sapropterin or sepapterin is permitted during Palynziq dose titration.

Yes

No

Q12. For reauthorization: Has the patient been approved for treatment with Palynziq previously?

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<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q13. Has the patient experienced any serious side effects (such as anaphylactic events) while being treated with Palynziq?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q14. Has the patient been compliant with filling their prescription?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q15. Is there documentation that the patient is stable on their current dose of Palynziq? Including documentation showing a blood phenylalanine concentration less than or equal to 600 micromol/L? Labs must be attached.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q16. Is there documentation showing the patient has not achieved a blood phenylalanine concentration less than or equal to 600 micromol/L after 24 weeks of continuous treatment with 20 mg subcutaneously once daily? Labs must be attached.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q17. Is there a titration plan in place showing that the patient's dosage will be increased to 40 mg subcutaneously once daily for at least 16 weeks?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q18. Is there documentation showing the patient has not achieved a blood phenylalanine concentration less than or equal to 600 micromol/L after 16 weeks of continuous treatment with 40 mg subcutaneously once daily? Labs must be attached.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q19. Is there documentation showing the patient's dosage will be increased to a maximum of 60 mg subcutaneously once daily for at least 16 weeks?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	



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Q20. Additional Information:

Prescriber Signature

Date

v2026-06