



MEDICAID / CHIP
PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Sephience - 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. Has the patient been previously approved for treatment? If YES, go to Q9. If NO, go to Q2.

Yes

No

Q2. Is Sephience being prescribed by or in consultation with a metabolic diseases specialist or a provider who specializes in the treatment of PKU?

Yes

No

Q3. Does the patient have a diagnosis of phenylketonuria confirmed by blood phenylalanine concentrations? Chart notes documenting diagnosis AND labs must be attached.

Yes

No

Q4. 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.

Yes

No

Q5. Is there documentation that Sephience will be used in combination with a Phe-restricted diet? Notes must be attached documenting patient is following a Phe-restricted diet in consultation with a nutritionist.

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<input type="checkbox"/> Yes	<input type="checkbox"/> No
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<p>Q6. Is there documentation showing the patient has tried generic sapropterin dihydrochloride for at least one month and meets ONE of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Has not achieved at least a 20% reduction in blood phenylalanine concentration from baseline at a max dose of 20mg/kg/day <input type="checkbox"/> Experienced at least a 20% reduction but blood phenylalanine concentration is still > 360mmol/L <input type="checkbox"/> Documentation of contraindication/intolerance to generic sapropterin dihydrochloride
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<p>Q7. Will this drug be used in combination with sapropterin products?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

<p>Q8. Will the patient receive concomitant Palynziq (pegvaliase-pqpz subcutaneous injection) at a stable maintenance dose? Note: Concomitant use with Palynziq is permitted during Palynziq dose titration.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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<p>Q9. Has the patient been compliant with filling their prescription?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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<p>Q10. Is the requested medication being used in combination with a phenylalanine (Phe)-restricted diet?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

<p>Q11. Has the patient experienced any serious side effects?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

<p>Q12. Has the patient had a reduction in blood phenylalanine concentration from baseline after maximally tolerated dose? Labs must be attached.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



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Q13. Will the patient receive concomitant Palynziq (pegvaliase-pqpz subcutaneous injection) at a stable maintenance dose? Note: Concomitant use with Palynziq is permitted during Palynziq dose titration?

Yes

No

Q14. Additional Information:

Prescriber Signature

Date

v2026-06