

Statement of Medical Necessity and Prescriptions for KUVAN® (sapropterin dihydrochloride) Tablets for Oral Use or Powder for Oral Solution (Page 1 of 2)

KUVAN Therapy: **Tablet** ☐ **Powder** ☐

For assistance, please contact BioMarin Patient and Physician Support (BPPS).
E-mail: **bpps@BMRN.com** Phone: **1-877-MY-KUVAN** (1-877-695-8826)
BPPS hours of operation: M-F, 6AM-5PM (PST)
Fax completed form with prescriber's signature to **1-888-863-3361** or **1-415-520-0548**.

PATIENT INFORMATION - Please fill out completely

Patient Name:		Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent/Guardian Name (if applicable):			
Street Address:		Suite/Floor/Apt:	
City:		State:	Zip Code:
Complete and Check Preferred Method of Contact	<input type="checkbox"/> Email Address:		
<input type="checkbox"/> Home Phone:	<input type="checkbox"/> Work Phone:	<input type="checkbox"/> Cell/Other Phone:	
Language Preferred: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:			

INSURANCE INFORMATION - Please attach copies of the insurance card, front and back

☐ **PATIENT HAS NO INSURANCE COVERAGE**

PRIMARY INSURANCE

Primary Insurance Name:	
Insurance Phone Number:	
Subscriber:	
Relationship to Patient:	
Member ID:	Group ID:
Employer:	

SECONDARY INSURANCE

Secondary Primary Insurance Name:	
Insurance Phone Number:	
Subscriber:	
Relationship to Patient:	
Member ID:	Group ID:
Employer:	

MEDICAL INFORMATION & STATEMENT OF MEDICAL NECESSITY - Please fill out completely

PRIMARY DIAGNOSIS

Short Description	ICD-9-CM	ICD-10-CM	Baseline Phe Levels (Before Trial):
<input type="checkbox"/> Classical Phenylketonuria (PKU)	270.1	E70.0	
<input type="checkbox"/> Other Hyperphenylalanemias (include additional specificity, if applicable)	270.1	E70.1	
(For ICD-9-CM other than 270.1 or ICD-10-CM other than E70.0 and E70.1, please contact BPPS)			

Prolonged elevated blood phenylalanine (Phe) levels can result in severe neurologic damage, including severe mental retardation, microcephaly, delayed speech, seizures, and behavioral abnormalities.

I am prescribing KUVAN for this patient, and find it medically necessary for the following reasons (check all that apply):

☐ I want to reduce Phe levels in this patient. ☐ Other:

Additional Comments:

Patient allergies? ☐ No Known ☐ Known

If Known allergies please list: _____

Please list the names of other medications the patient is currently taking: ☐ None

Please list Medications: _____

KUVAN®
(sapropterin dihydrochloride)
Tablets or Powder for Oral Solution

BPPS
BioMarin Patient & Physician Support

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Statement of Medical Necessity and Prescriptions for KUVAN® (sapropterin dihydrochloride) Tablets for Oral Use or Powder for Oral Solution (Page 2 of 2)

PATIENT NAME: _____

PATIENT DATE OF BIRTH: _____

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PROVIDERS, PLEASE COMPLETE BOTH PRESCRIPTIONS BELOW:

STARTER AND KUVAN PATIENT ASSISTANCE PROGRAM PRESCRIPTION (K-PAP) For use by PAP Pharmacy only

ALL PATIENTS RECEIVE A FREE 30-DAY STARTER SUPPLY OF KUVAN.
Refills are for Kuvan Patient Assistance Program (K-PAP) only if necessary. A patient may be uninsured and still seek access to KUVAN (sapropterin dihydrochloride) Tablets/Powder.

Dose per kg Body Weight: <input type="checkbox"/> 10 mg/kg <input type="checkbox"/> 20 mg/kg <input type="checkbox"/> Other _____ mg/kg		Current Weight: _____ kg
Number of mg per Day:	Number of Days Supply/Rx: <input type="checkbox"/> 30 days <input type="checkbox"/> 90 days	Number of Refills: 12
<input type="checkbox"/> KUVAN, Tablet 100 mg / Number of 100 mg Tablets per Day: _____ (NDC Number: 68135-0300-02)		
<input type="checkbox"/> KUVAN, Powder 100 mg / Number of 100 mg Powder Packets per Day: _____ (NDC Number: 68135-0301-11)		
<input type="checkbox"/> KUVAN, Powder 500 mg / Number of 500 mg Powder Packets per Day: _____ (NDC Number: 68135-0482-10)		
Patient Directions (check all that apply): <input type="checkbox"/> Please contact your physician before starting use of this medication. <input type="checkbox"/> Take _____ 500mg (powder) and _____ 100mg (powder) once daily, as directed, with meal, for a total dose of _____ mg/day <input type="checkbox"/> Take _____ 100mg (tablet) once daily as directed, with meal, for a total dose of _____ mg/day <input type="checkbox"/> Other: _____		Shipping Instructions (check if applicable): <input type="checkbox"/> Dispensing pharmacy to notify prescriber when initial shipment is scheduled.
_____ <input type="checkbox"/> Signature/ Substitution permitted _____ Date		_____ <input type="checkbox"/> Signature/ Dispense as written _____ Date

(No Stamps or Initials) (If you are a New York Prescriber, Please use an original New York State Prescription Form)

PRESCRIPTION (For Use by In-Network Specialty Pharmacy)		
Dose per kg Body Weight: <input type="checkbox"/> 10 mg/kg <input type="checkbox"/> 20 mg/kg <input type="checkbox"/> Other _____ mg/kg		Current Weight: _____ kg
Number of mg per Day:	Number of Days Supply/Rx: <input type="checkbox"/> 30 days <input type="checkbox"/> 90 days	Number of Refills: 12
<input type="checkbox"/> KUVAN, Tablet 100 mg / Number of 100 mg Tablets per Day: _____ (NDC Number: 68135-0300-02)		
<input type="checkbox"/> KUVAN, Powder 100 mg / Number of 100 mg Powder Packets per Day: _____ (NDC Number: 68135-0301-11)		
<input type="checkbox"/> KUVAN, Powder 500 mg / Number of 500 mg Powder Packets per Day: _____ (NDC Number: 68135-0482-10)		
Patient Directions (check all that apply): <input type="checkbox"/> Please contact your physician before starting use of this medication. <input type="checkbox"/> Take _____ 500mg (powder) and _____ 100mg (powder) once daily, as directed, with meal, for a total dose of _____ mg/day <input type="checkbox"/> Take _____ 100mg (tablet) once daily as directed, with meal, for a total dose of _____ mg/day <input type="checkbox"/> Other: _____		Shipping Instructions (check if applicable): <input type="checkbox"/> Dispensing pharmacy to notify prescriber when initial shipment is scheduled.
_____ <input type="checkbox"/> Signature/ Substitution permitted _____ Date		_____ <input type="checkbox"/> Signature/ Dispense as written _____ Date

(No Stamps or Initials) (If you are a New York Prescriber, Please use an original New York State Prescription Form)

PRESCRIBER INFORMATION - Please fill out completely		
Prescriber’s Full Name:		
Office/Site/Clinic:		Office Contact:
Phone:	Fax:	Email:
Address:		
Address:		
City:	State:	Zip:
License Number:	DEA Number:	Medicaid Number:
Tax ID:	NPI Number:	
Prescriber Declaration I verify that the patient and prescriber information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed KUVAN based on my professional judgment of medical necessity. I authorize BioMarin or its affiliated companies or subcontractors to forward this prescription electronically, by facsimile, or by mail to a dispensing pharmacy chosen by the above-named patient. I also authorize the BPPS program to perform any steps necessary to obtain reimbursement for KUVAN, including but not limited to insurance verification and case assessment. I understand that BPPS may need additional information, and I agree to provide it as needed for the purposes of reimbursement.		
Prescriber’s Full Signature (REQUIRED): (No Stamps or Initials)		Date: