Updated: 07/2019
DMMA Approved: 08/2019

Request for Prior Authorization for Ravicti (glycerol phenylbutyrate)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Ravicti (glycerol phenylbutyrate) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Ravicti (glycerol phenylbutyrate) Prior Authorization Criteria:

Coverage may be provided with a diagnosis of a urea cycle disorder (UCD) and the following criteria is met:

- Must be prescribed by or in consultation with a physician experienced in treating metabolic disorders
- Diagnosis must be confirmed by enzymatic, biochemical, or genetic testing
- Must be used for chronic management of UCD
- Must provide documentation showing the member has tried and failed dietary protein restriction or amino acid supplementation
- Must provide documentation showing the member has tried and failed (which will be verified via pharmacy claims if available) or had an intolerance or contraindication to sodium phenylbutyrate (prior authorization may be required)
- Must be used in combination with dietary protein restriction
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:** 3 months
- **Reauthorization criteria**
    - Documentation of clinical improvement
    - Medication is being used in combination with dietary protein restriction
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

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RAVICTI (GLYCEROL PHENYLBUTYRATE)
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6253 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:

☐ **Urea Cycle Disorder**, ICD-10: _____

- Has the diagnosis been confirmed by enzymatic, biochemical, or genetic testing? ☐ Yes ☐ No
- Is this being used for chronic management? ☐ Yes ☐ No
- Has dietary protein restriction been tried? ☐ Yes ☐ No
- Has amino acid supplementation been tried? ☐ Yes ☐ No
- Has sodium phenylbutyrate been tried? ☐ Yes, please list below ☐ No
- Will this be used in combination with dietary protein restriction? ☐ Yes ☐ No

☐ **Other:** _____ ICD-10: _____

Is this prescribed by or in consultation with a physician experienced in treating metabolic disorders? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Is this being used in combination with dietary protein restriction? ☐ Yes ☐ No

Has the member experienced clinical improvement with treatment? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date