Physician Request Form Kuvan™
Fax to Pharmacy Services at **855-811-9332**, or to speak to a Representative, call **888-602-3741**. *Form must be completed for processing.*

Patient Name: ____________________ Patient ID#: ____________________

Address: ____________________ Apt # or Suite #: ____________________

City: ____________________ State: __________ Zip Code: ____________________

Phone #: __________ Height: ________ Weight: ________lbs = ________Kg Birth Date: ____________________

Physician Name: ____________________ NPI #: ____________________

Address: ____________________ Apt # or Suite #: ____________________

City: ____________________ State: __________ Zip Code: ____________________

Contact Person: ____________________ Phone #: __________ Fax #: ____________________

Physician Signature: ____________________ Date: ____________________

Diagnosis: ____________________ ICD-9 Diagnosis Code: ____________________

Sig (How Administered): ____________________

❑ **A. For patients with a diagnosis of Phenylketonuria (PKU):**

- **Is this patient currently utilizing a Phe-restricted diet with Phe free medical products/foods? (please check)**
  ❑ **Yes (if yes please attach any receipts or order forms that the patients has-failure to do so could result in a delay in any possible approvals)** ❑ **No, then why** ____________________
  ____

- **Dosage being prescribed for the patient. =** ____________________ **mg/kg/day**
  Patients weight __________ **lbs or** __________ **kg =** ____________________ **mg/day**

❑ ***Lab Results*** *(Please submit a copy of the most recent labs and/or complete the following - lab values should be within 30 days of request)*

Date of Lab Results	Blood Phe Levels	Date of Lab Results	Blood Phe Levels
1.	1. Baseline results =	6.	6.
2.	2.1st result during the initial month of treatment =	7.	7.
3.	3.2nd result during the initial month of treatment=	8.	8.
4.	4.	9.	9.
5.	5.	10.	10.

❑ **B. Diagnosis other than Phenylketonuria (PKU:**

- **Rationale for choosing this treatment, please include all applicable documentation**____________________

IMPORTANT AUTHORIZATION INFORMATION: Kuvan™ will only be authorized for a **ONE MONTH** duration for the **INITIAL AUTHORIZATION**. At that point, for any patient that requires an increase in dose of up to 20 mg/kg/day his/her second authorization will be for a **ONE MONTH** duration. Reauthorization will require that documentation of the patient's blood Phe level, the patient's weight, and documentation (e.g. receipts, order forms) supporting that the patient is utilizing a Phe restricted diet with Phe free medical products/foods be submitted with each request.