

Cuvrior (trientine tetrahydrochloride) Prior Authorization Request Form



Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

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MEMBER INFORMATION		
LAST NAME:	FIRST NAME:	
PHONE NUMBER:	DATE OF BIRTH:	
STREET ADDRESS:		
CITY:	STATE: ZIP CODE:	
PATIENT INSURANCE ID NUMBER:		

MALE FEMALE HEIGHT (IN/CM): _____ WEIGHT (LB/KG): _____ ALLERGIES: _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: <u>HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF</u>

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): ______

AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: ______

PRESCRIBER INFORMATION			
LAST NAME:	FIRST NAME:		
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:		
NPI NUMBER:	DEA NUMBER:		
PHONE NUMBER:	FAX NUMBER:		
STREET ADDRESS:			
CITY:	STATE: ZIP CODE:		
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:		

MEDICATION OR MEDICAL DISPENSING INFORMATION				
MEDICATION NAME:				
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:	
NEW THERAPY	RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:		
DURATION OF THERAPY (SPECIFIC DATES):				

Continued on next page.





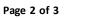


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MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:			
1. HAS THE PATIENT TRIED ANY OTHEI	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) 🗌 NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:		
2. LIST DIAGNOSES:		ICD-10:		
 Wilson's disease Other diagnosis: 				
3. REQUIRED CLINICAL INFORMATION PRIOR AUTHORIZATION.	I: PLEASE PROVIDE ALL RELEVANT CLIN	ICAL INFORMATION TO SUPPORT A		
Clinical Information:				
Will Cuvrior be used as part of a clinic	al trial? 🗆 Yes 🗆 No			
Does the patient have a diagnosis of Wilson's disease, as defined by a prior or current Leipzig score of at least 4?				
Has the patient previously been treated with penicillamine for at least 1 year? \square Yes $\ \square$ No				
Will the patient discontinue penicillamine before initiating Cuvrior? \square Yes \square No				
Will the patient have concurrent use with another formulation of trientine? \square Yes $\ \square$ No				
<u>Renewal Criteria:</u> Does the patient continue to demonstrate a positive clinical response? — Yes — No				
Does the patient exhibit clinical manifestations of advancement of Wilson's disease from baseline (e.g., jaundice, edema, ascites, esophageal varices, liver failure, central nervous system symptoms? Yes No				
Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?				
Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.				
ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.				
Prescriber Signature or Electronic I.D. Verification: Date: Date:				







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FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program

Attn: CP – 4201 P.O. Box 64811 St. Paul, MN 55164-0811



