

## Olpruva Pellet (sodium phenylbutyrate) 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.

			☐ URGENT	
MEMBER INFORMATION				
LAST NAME:		FIRST NAME:		
PHONE NUMBER:		DATE OF BIRTH:		
STREET ADDRESS:				
CITY:		STATE: ZIP CODE:		
PATIENT INSURANCE ID NU	MBER:	1		
☐ MALE ☐ FEMALE HEIG	GHT (IN/CM): WEIG	HT (LB/KG): ALLERG	GIES:	
IF YOU ARE NOT THE PATIENT OR THE PRESCR FOLLOWING LINK: HTTPS://MAGELLANRX.CO	*			
PATIENT'S AUTHORIZED REPF	•			
PRESCRIBER INFORMATION		FIDCT MANAGE		
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:		
		1		
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 (SPE	ECIFIC DATES):			

Continued on next page.



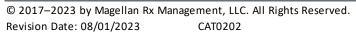


## Olpruva Pellet (sodium phenylbutyrate) Prior Authorization Request Form



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

MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:		
1. HAS THE PATIENT TRIED ANY OTHE	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO	
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	<b>DURATION OF THERAPY</b> (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:	
2. LIST DIAGNOSES:		ICD-10:	
<ul><li>□ Urea cycle disorders (UCD)</li><li>□ Other diagnosis:</li></ul>	ICD-10:		
<b>3. REQUIRED CLINICAL INFORMATION</b> PRIOR AUTHORIZATION.	N: PLEASE PROVIDE ALL RELEVANT CLIN	ICAL INFORMATION TO SUPPORT A	
Clinical Information:			
Will drug be used as part of a clinical	trial? 🗆 Yes 🗆 No		
Does the patient have a diagnosis of	a urea cycle disorder? □ Yes □ No		
Will the patient be on a protein restr	icted diet while taking Olpruva? □ Yes	□ No	
Has the patient tried and failed a 3-m	onth trial of sodium phenylbutyrate (g	generic Buphenyl)? 🗆 Yes 🗆 No	
Is the medication being prescribed b  ☐ Yes ☐ No	y a physician experienced in managem	ent of UCDs (e.g. geneticist)?	
Renewal Criteria:			
Does the patient continue to be on a	protein restricted diet? ☐ Yes ☐ No		
Does the patient continue to demon	strate a positive clinical response (doc	umentation required)? 🗆 Yes 🗆 No	
Are there any other comments, diagn physician feels is important to this re	oses, symptoms, medications tried or faview?	iled, and/or any other information the	
<b>Please note:</b> Not all drugs/diagnosis a information is received.	re covered on all plans. This request ma	y be denied unless all required	
the Health Plan, insurer, Medical Grou	n provided is true and accurate to the bo p or its designees may perform a routine curacy of the information reported on th	e audit and request the medical	
Prescriber Signature or Electronic I.D.	Verification:	Date:	









## Olpruva Pellet (sodium phenylbutyrate) Prior Authorization Request Form



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

**CONFIDENTIALITY NOTICE:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

**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

© 2017–2023 by Magellan Rx Management, LLC. All Rights Reserved. Revision Date: 08/01/2023 CAT0202

Page 3 of 3



