sunshine health

MEDICATION PRIOR AUTHORIZATION REQUEST FORM
FAX this completed form to 1-833-546-1507
OR Mail request to: Pharmacy Services Prior Authorization Dept.
5 River Park Place East, Suite 210 | Fresno, CA 93720

Reset Form | Print Form

Call 1-866-399-0928 to request a 72-hour supply of medication.
Pharmacy Services will respond via fax or phone within 24 hours of receipt of all necessary information, expect during weekends and holidays. For immediate response on weekends and holidays, NurseWise will answer your call.

NITISINONE (Orfadin®, Nityr®)
(Maximum Length of Therapy is 12 Months)

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID #

Date of Birth (MM/DD/YYYY) ___ / ___ / ____

Recipient's Full Name

Prescriber's Full Name

Prescriber's NPI

Prescriber Phone Number ___ - ___ - ____

Prescriber Fax Number ___ - ___ - ____

Pharmacy Name

Pharmacy Medicaid Provider #

Pharmacy Phone Number ___ - ___ - ____

Pharmacy Fax Number ___ - ___ - ____

1. Is the patient's diagnosis hereditary tyrosinemia type I?
   ☐ Yes ☐ No
2. Are the dietary restrictions of tyrosine and phenylalanine alone sufficient to maintain the urinary succinylacetone at or below detectable levels?
   ☐ Yes ☐ No
3. Is this patient currently placed on a liver transplantation waiting list?
   ☐ Yes ☐ No
4. In your opinion, will this patient likely become a candidate for liver transplantation within the next year?
   ☐ Yes ☐ No
5. The patient's current weight is _____ kg.

Prescriber's Signature: _____ **Date:** _____

REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

NITISINONE (Orfadin®, Nityr®)

(Maximum Length of Therapy is 12 Months)

Note: Form must be completed in full. An incomplete form may be returned.

Review Criteria

1. If the patient can be maintained on dietary restrictions alone, Orfadin® or Nityr® is not approved. (If the answer to question two is **YES**, do not approve.)
2. If the patient is on a liver transplantation list, approval period is only for six months.
3. If in the physician's opinion, the patient will become a liver transplant candidate within the next year, the approval period is only six months.
4. All other approvals are for a one-year period.
5. Limit the dose to 2 mg/kg for Orfadin® and Nityr®.
6. Orfadin® is packaged in a high density (HD) polyethylene container of **60 capsules and cannot be repackaged and dispensed in a different container** or a 90mL suspension is available of 4 mg/mL.
7. Nityr® is available in tablet formulation.