Print Form Reset Form

FLORIDA MEDICAID

Prior Authorization

Orfadin®

(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 License # (ME, OS, ARNP, PA)

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: Copies of medical records (i.e., diagnostic evaluations and recent chart notes), a copy of the original prescription, and the most recent copies of related labs.
The provider must retain copies of all documentation for five years.

Fax Information to:

PERFORMRx℠

Pharmacy Provider Services
Fax: 855-825-2717
Phone: 1-800-617-5727

Review Criteria

1. If the patient can be maintained on dietary restrictions alone, Orfadin® 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 2mg per Kg plus a 25 percent growth factor.
6. Orfadin is packaged in a high density (HD) polyethylene container of **60 capsules and cannot be repackaged and dispensed in a different container**.