

FLORIDA MEDICAID PRIOR AUTHORIZATION

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)																		
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Prescriber's Full Name																													
Prescriber's NPI																													
Pres	criber Phone Number														Pres	crib	er Fa	χ Νι	ımbe	er				•					
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Pharmacy Name																													
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1.	I	s the	e pa	tient	's dia	agno	sis h	nered	ditary	y tyro	osine	emia	typ:	e I?	0	Yes			0 1	10									
2.		Are t	he c	dieta	ry re	stric	tions	of t	yrosi	ine a	ınd p	ohen	ıylala	anine	e alo	ne s	uffic	ient	to ma	ainta	in th	ie ur	inar	y suc	ciny	lace	tone	at o	r
					able				-			No	•												•				
3.	3. Is this patient currently placed on a liver transplantation waiting list? O Yes O No																												
4.	I	n yo	ur o	pinic	n, w	ill th	is pa	atien	t like	ly be	econ	ne a	can	dida	te fo	r live	r tra	nspl	anta	tion v	withi	n th	e ne	xt ye	ar?				
			(YC	es		С	No.)																				
5. The patient's current weight is														kg.															
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	scrib		•															Date:ations and recent chart notes), and the most recent											
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The provider must retain copies of all documentation for five years.

Mail or Fax Information to:

Magellan Medicaid Administration, Inc. Prior Authorization P. O. Box 7082 Tallahassee, FL 32314-7082

Phone: 877-553-7481 Fax: 877-614-1078 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 (via return fax) immediately and arrange for the return or destruction of these documents. Distribution, reproduction or any other use of this transmission by any party other than the intended recipient is strictly prohibited.

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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®.
- 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 90 mL suspension is available of 4 mg/mL.
- 7. Nityr® is available in tablet formulation.