

FLORIDA MEDICAID PRIOR AUTHORIZATION

NITISINONE (Orfadin<sup>®</sup>, Nityr<sup>®</sup>)



(Maximum Length of Therapy is 12 Months)

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

Rec	Recipient's Medicaid ID # Da										Date	Date of Birth (MM/DD/YYYY)																			
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Pharmacy Phone Number Pharmacy Fax Number																															
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3.	<ol> <li>Are the dietary restrictions of tyrosine and phenylalanine alone sufficient to maintain the urinary succinylacetone at or below detectable levels? O Yes O No</li> <li>Is this patient currently placed on a liver transplantation waiting list? O Yes O No</li> </ol>																														
4. In your opinion, will this patient likely become a candidate for liver transplantation within the next year?																															
O Yes O No 5. The patient's current weight is													kg.																		
copies													i.e., diagnostic evaluations and recent chart notes), and the most recent pies of related labs.																		
Auth Phor Phor Fax	<b>Call or Fax Information to:</b> Florida Community Care Prior Authorization Phone number for non-specialty Prior Authorization: 877-433-7643 Phone number for specialty Prior Authorization: 866-814-5506 Fax number for non-specialty Prior Authorization: 866-255-7569 Fax number for non-specialty Prior Authorization: 866-249-6155											43	<ul> <li>ain copies of all documentation for five years.</li> <li>Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipien 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.</li> </ul>														ance for				



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## **Review Criteria**

- 1. If the patient can be maintained on dietary restrictions alone, Orfadin<sup>®</sup> or Nityr<sup>®</sup> 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<sup>®</sup> 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<sup>®</sup> is available in tablet formulation.