

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 #

Grid for Recipient's Medicaid ID #

Date of Birth (MM/DD/YYYY)

Grid for Date of Birth (MM/DD/YYYY)

Recipient's Full Name

Grid for Recipient's Full Name

Prescriber's Full Name

Grid for Prescriber's Full Name

Prescriber's NPI

Grid for Prescriber's NPI

Prescriber Phone Number

Grid for Prescriber Phone Number

Prescriber Fax Number

Grid for Prescriber Fax Number

Pharmacy Name

Grid for Pharmacy Name

Pharmacy Medicaid Provider #

Grid for Pharmacy Medicaid Provider #

Pharmacy Phone Number

Grid for Pharmacy Phone Number

Pharmacy Fax Number

Grid for Pharmacy Fax Number

- 1. Is the patient's diagnosis hereditary tyrosinemia type I?
2. Are the dietary restrictions of tyrosine and phenylalanine alone sufficient to maintain the urinary succinylacetone at or below detectable levels?
3. Is this patient currently placed on a liver transplantation waiting list?
4. In your opinion, will this patient likely become a candidate for liver transplantation within the next year?
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), and the most recent copies of related labs.

The provider must retain copies of all documentation for five years.

Call or Fax Information to: 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

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



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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<sup>®</sup> and Nityr<sup>®</sup>.
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.