**Reset Form** 

**Print Form** 



## Aetna Better Health® of Florida (MEDICAID)

# **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)																		
														1			1												
Reci	pien	t's F	ull N	ame	!	,								-			-			!									
Prescriber's Full Name																													
Pres	cribe	er's l	NPI			1			i	1	•				•				•					•					
Pres	cribe	riber Phone Number														Prescriber Fax Number													
			-				-														-				-				
Pharmacy Name																													
Pharmacy Medicaid Provider #																													
 Phar	mac																												
			-				-														-				-				
1.		s the	e pa	tient	's dia	agno	sis h	nerec	ditar	v tvr	osine	emia	a typ	e I?	0	Yes			0 1	10									
			•			Ū				, ,			,,																
2. Are the dietary restrictions of tyrosine and phenylalanine alone sufficient to maintain the urinary										, cu c	ciny	laco	tono	at o	r														
2.					-	leve		-		IIIC c		No	-	armi	c alc	л IC 3	unic	ieni i	LO III	aiiita	111 (1	ie ui	ıııaı	y suc	Cirry	iace	lone	at 0	1
3. Is this patient currently placed on a liver transplantation waiting list? O Yes O No																													
٥.		3 1111	s pe	ilicii	Curi	Cita	уріа	ceu	OII 6	IIVC	ппа	порі	ante	itiOii	wait	ii ig ii	131:		163	`	9 11								
4.	ı	In your opinion, will this patient likely become a candidate for liver transplantation within the next year?																											
		,		D Y				No		,								•						,					
																lea.													
5.		ше	pau	rii S	curr	ent (	weig	IIL IS										kg.											
Pre	Prescriber's Signature:																	D	ate:										
F	REQI	JIRE	D F	OR R	EVIE	:W: C	opie	s of	med	lical	reco	rds	(i.e.,	diag	nost	ic ev	alua	tions	and	rece	nt c	hart	note	s), a	nd th	e me	ost r	ecen	t

copies of related labs.

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

Fax completed prior authorization request form to Aetna Better Health of Florida at 855-799-2554 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

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.



#### Aetna Better Health® of Florida (MEDICAID)

# 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<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®.
- 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® is available in tablet formulation.