# BioMarin Patient and Physician Support (BPPS) Enrollment Forms

for

# KUVAN

KUVAN®
(sapropterin dihydrochloride) Tablets

BPPS
BioMarin Patient & Physician Support

# Instructions

## for Completing Statement of Medical Necessity (SMN) and Prescription for KUVAN

**If you need assistance with the attached form, please contact:**

**BioMarin Patient and Physician Support (BPPS)**
**E-mail: bpps@BMRN.com**
**P: 1-877-MY-KUVAN (1-877-695-8826), F: 1-888-863-3361 or 1-415-520-0548**
**BPPS hours of operation: M–F, 7AM–4 PM (PT)**

### 1) Patient Information

Complete all sections: patient name, parent/guardian name (if applicable), mailing address, date of birth, sex, preferred method of contact, daytime/evening phone numbers, alternate phone number (if applicable), e-mail address, and language preference.

### 2) Insurance Information

Complete all sections for primary and secondary (if applicable) prescription benefits: check the type of plan the patient currently has, and indicate insurance name, phone number, subscriber, relationship to patient, group ID, member ID, and employer. Please also attach a copy of the front and back of the insurance card to this SMN.

### 3) Medical Information and Statement of Medical Necessity

Complete primary diagnosis and the section stating the medically necessary reason for prescribing KUVAN. Check the boxes that apply to your patient and add any additional comments as necessary. Also indicate whether any medication allergies exist.

### 4) Prescription

Please ensure that you complete all areas of the prescription legibly, accurately, and completely. Fill in the current weight section—please note that the weight should be reported in kilograms. Ensure that you have indicated the total dose in mg/kg body weight: select 10 mg/kg, 20 mg/kg, or fill in the "other" mg/kg dosing schedule. Indicate the number of days you are prescribing, the number of tablets and mg per day, and any refills that are available to the patient. Mark the patient directions and shipping instructions that you prefer. Please sign and date the form to make the prescription valid. **A prescription cannot be processed without a prescriber's full signature (no stamps or initials).**

### 5) Prescriber Declaration

Please review, sign, and date the declaration.

### 6) Prescriber Information

Complete all sections: prescriber's full name, office/site/clinic name, office contact (if different from prescriber), address, phone/fax numbers, e-mail, license number, DEA number, Medicaid number, tax ID, and NPI number.

### 7) Fax both pages of the completed SMN to BPPS at 1-888-863-3361 or 1-415-520-0548.

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# Statement of Medical Necessity and Prescriptions

## for KUVAN (Page 1 of 2)

For assistance, please contact BioMarin Patient and Physician Support (BPPS).
E-mail: bpps@BMRN.com | Phone: **1-877-MY-KUVAN (1-877-695-8826)**
BPPS hours of operation: M–F, 6AM-5PM (PST)
Fax completed form with prescriber's signature to **1-888-863-3361** or **1-415-520-0548.**

### PATIENT INFORMATION

| | | |
|---|---|---|
| Patient Name: | Date of Birth: | Sex: ☐ Male ☐ Female |
| Parent/Guardian Name (*if applicable):* | | |
| Street Address: | | Suite/Floor/Apt: |
| City: | State: | Zip: |
| Home Phone: | Work Phone: | Cellular/Other Phone: |
| E-mail Address: | | Preferred Method of Contact: ☐ E-mail ☐ Phone *circle one*: **Home** \| **work** \| **other** |
| Language Preferred: ☐ English ☐ Spanish ☐ Other: | | |

### INSURANCE INFORMATION – Please attach copies of the insurance card – front and back

☐ **Patient has no known coverage for prescription drugs**

| PRIMARY PRESCRIPTION BENEFIT | | | |
|---|---|---|---|
| ☐ HMO | ☐ PPO | ☐ Medicaid/CHIPs | ☐ Other |
| Primary Insurance Name: | | | |
| Insurance Phone Number: | | | |
| Subscriber: | | | |
| Relationship to Patient: | | | |
| Member ID: | Group ID: | | |
| Employer: | | | |

| SECONDARY PRESCRIPTION BENEFIT | | | |
|---|---|---|---|
| ☐ HMO | ☐ PPO | ☐ Medicaid/CHIPs | ☐ Other |
| Secondary Insurance Name: | | | |
| Insurance Phone Number: | | | |
| Subscriber: | | | |
| Relationship to Patient: | | | |
| Member ID: | Group ID: | | |
| Employer: | | | |

### MEDICAL INFORMATION & STATEMENT OF MEDICAL NECESSITY

**Primary Diagnosis** (For ICD-9-CM other than 270.1, please contact BPPS)

| ICD-9-CM | AMA Description |
|---|---|
| ☐ 270.1 | Phenylketonuria (PKU), includes hyperphenylalaninemia |

Prolonged elevated blood phenylalanine (Phe) levels can result in severe neurologic damage, including severe mental retardation, microcephaly, delayed speech, seizures, and behavioral abnormalities.

I am prescribing KUVAN for this patient, and find it medically necessary for the following reasons (check all that apply):

☐ I want to reduce Phe levels in this patient. ☐ Other:

Additional Comments:

Any known medication allergies? ☐ No ☐ Yes If Yes please list:

KUVAN® (saproterin dihydrochloride) Tablets

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# Statement of Medical Necessity and Prescriptions

## for KUVAN (Page 2 of 2)

**PATIENT NAME:** _____

**Patient Date of Birth:** _____

For assistance, please contact BioMarin Patient and Physician Support (BPPS).
E-mail: bpps@BMRN.com | Phone: **1-877-MY-KUVAN (1-877-695-8826)**
BPPS hours of operation: M–F, 6AM-5PM (PST)
Fax completed form with prescriber's signature to **1-888-863-3361** or **1-415-520-0548.**

**Please Complete BOTH Prescriptions Below:**

### STARTER Prescription Only

| | | |
|---|---|---|
| Product Name: *KUVAN, 100 mg Tablets* | NDC Number: 68135-0300-02 | |
| Current Weight: kg | Dose per Kg Body Weight: ☐ 10 mg/kg ☐ 20 mg/kg ☐ Other mg/kg | Number of Days/Rx: 30 days |
| Number of Tablets per Day: | Number of Mg per Day: | Number of Refills: 0 |

**Patient Directions** (check all that apply):
- ☐ **Please contact your physician before starting use of this medication.**
- ☐ Take tablets once daily with food.
- ☐ Other:

**Shipping Instructions** (check if applicable):
- ☐ Dispensing pharmacy to notify prescriber when initial shipment is scheduled.

Prescriber's Full Signature: _____ Date: _____

**(No Stamps or Initials) (If you are a New York Prescriber, Please use an original New York State Prescription Form)**

☐ Dispense as Written ☐ Substitution permitted

### Prescription (For Use by In-Network Specialty Pharmacy)

| | | |
|---|---|---|
| Product Name: *KUVAN, 100 mg Tablets* | NDC Number: 68135-0300-02 | |
| Current Weight: kg | Dose per Kg Body Weight: ☐ 10 mg/kg ☐ 20 mg/kg ☐ Other mg/kg | Number of Days/Rx: 30 day |
| Number of Tablets per Day: | Number of Mg per Day: | Number of Refills: 12 |

**Patient Directions** (check all that apply):
- ☐ **Please contact your physician before starting use of this medication.**
- ☐ Take tablets once daily with food.
- ☐ Other:

**Shipping Instructions** (check if applicable):
- ☐ Dispensing pharmacy to notify prescriber when initial shipment is scheduled.

Prescriber's Full Signature: _____ Date: _____

***(No Stamps or Initials) (If you are a New York Prescriber, Please use an original New York State Prescription Form)***

☐ Dispense as Written ☐ Substitution permitted

### Prescriber Information

| | | |
|---|---|---|
| Prescriber's Full Name: | | |
| Office/Site/Clinic: | Office Contact: | |
| Phone: | Fax: | Email: |
| Address: | | |
| Address: | | |
| City | State: | Zip: |
| License Number: | DEA Number: | Medicaid Number: |
| Tax ID: | NPI Number: | |

***Prescriber Declaration***

I verify that the patient and prescriber information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed KUVAN based on my professional judgment of medical necessity. I authorize BioMarin or its affiliated companies or subcontractors to forward this prescription electronically, by facsimile, or by mail to a dispensing pharmacy chosen by the above-named patient. I also authorize the BPPS program to perform any steps necessary to obtain reimbursement for KUVAN, including but not limited to insurance verification and case assessment. I understand that BPPS may need additional information, and I agree to provide it as needed for the purposes of reimbursement.

Prescriber's Full Signature: _____ Date: _____

(No Stamps or Initial)