

Prescriber Criteria Form
Phenylbutyrate 2026 PA Fax 965-A v3 010126.docx
Buphenyl, Olpruva, Pheburane (sodium phenylbutyrate)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Phenylbutyrate.

Drug Name (select from list of drugs shown):

Patient Name:

Patient ID:

Patient DOB: **Patient Phone:**

Prescriber Name:

Prescriber Address:

City: **State:** **Zip:**

Prescriber Phone: **Prescriber Fax:**

Diagnosis: **ICD Code(s):**

Please circle the appropriate answer for each question.

1	Is the requested drug being prescribed for chronic management of urea cycle disorder? [If no, then no further questions.]	Yes	No
2	Was the diagnosis of urea cycle disorder confirmed by enzymatic, biochemical, or genetic testing?	Yes	No

Comments: _____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:** _____