

HealthAlliance**MEDICARE**

PURPOSE OF THE POLICY

To define the criteria for coverage of Kuvan tablets (sapropterin hydrochloride).

STATEMENT OF THE POLICY

Kuvan tablets (sapropterin hydrochloride) will be covered if the following criteria are met, for new starts only:

PROCEDURES

1. Coverage Criteria requires all of the following:

- 1.1 Approved for FDA approved indications.
- 1.2 Initial approval is for two (2) month.
- 1.3 Prior authorization is to monitor if patient is a responder or nonresponder after therapy has been initiated for two (2) months. If phenylalanine levels have decreased after the 2 months, then authorization will continue.