**Louisiana Medicaid**
**Sepiapterin (Sephience™)**

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for sepiapterin (Sephience™).

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available HERE.

**Approval Criteria for Initiation of Therapy**

- The recipient is 1 month of age or older on the date of the request; **AND**
- The recipient has a diagnosis of hyperphenylalaninemia (HPA) with sepiapterin-responsive phenylketonuria (PKU); **AND**
- The recipient is following a phenylalanine (Phe)-restricted diet**.**

**Duration of authorization approval when initiating treatment or increasing dosage to determine response to therapy: 1 month**

**Approval Criteria for Continuation of Therapy**

- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy by a decreased blood Phe from baseline.

**Duration of approval for continuation of therapy after response to therapy has been determined: 12 months**

**References**

Sephience (sepiapterin) [package insert]. Warren, NJ: PTC Therapeutics, Inc; July 2025. https://www.sephience.com/wp-content/uploads/prescribing-information.pdf

| Revision / Date | Implementation Date |
|---|---|
| Policy created / September 2025 | April 2026 |