JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Cerezyme and VPRIV

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ Same as Referring Provider ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Drug Information:

Strength/Measure _____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un

Directions(sig) _____ *Route of administration* _____

Dosing frequency _____

Site of Service Questions:

A. Indicate the site of service requested:
- ❑ On Campus Outpatient Hospital
- ❑ Off Campus Outpatient Hospital
- ❑ Home based setting, *skip to Criteria Questions*
- ❑ Community office, *skip to Criteria Questions*
- ❑ Ambulatory infusion site, *skip to Criteria Questions*

B. Is the patient less than 18 years of age?
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No

C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre- medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.jhhc.com

D. seizures) during or immediately after an infusion? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation***. ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation***.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

H. Has the patient's home been deemed not eligible or appropriate for home infusion services by a home infusion provider? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

I. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?
ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation. ❑ Yes ❑ No

Criteria Questions:

A. What is the prescribed drug? ❒ Cerezyme ❒ VPRIV ❒ Other _____

B. What is the ICD-10 code? _____

1. What is the diagnosis?

❒ Gaucher disease (If checked, go to 2)

❒ Other, please specify. _____ (If checked, go to 2)

2. Was the diagnosis of Gaucher disease confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase (glucosidase) enzyme activity or by genetic testing? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s) or test results.

❒ Yes (If checked, go to 3)

❒ No (If checked, go to3)

3. Which variant of Gaucher disease does the patient have?

❒ Type 1 (If checked, go to 4)

❒ Type 2 (If checked, go to 4)

❒ Type 3 (If checked, go to 4)

❒ Other, please specify _____ (If checked, go to 4)

Send completed form to: Priority Partners Fax: 1-866-212-4756

4. Is this request for continuation of treatment with the requested drug?

❒ Yes (If checked, go to 5)

❒ No (If checked, go to 6)

5. Is the patient experiencing an inadequate response or any intolerable adverse events from therapy with the requested drug?

❒ Yes (If checked, go to 6)

❒ No (If checked, go to 6)

6. What is the patient's body weight?

❒ Less than or equal to 100 kg (220.5 lbs) (If checked, *no further questions*)

❒ Greater than 100 kg (220.5 lbs) (If checked, *no further questions*)

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Priority Partners Fax: 1-866-212-4756