Elelyso

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 along with supporting clinical documentation 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*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

Drug Information:

Strength/Measure _____*Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
Directions(sig) _____*Route of administration* _____
Dosing frequency _____

What is the ICD-10 code? _____

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

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

Exception Criteria Questions:

A. Is the product being requested for the treatment of Gaucher disease type 1?
❑ Yes ❑ No *If No, skip to Criteria Questions*

B. The preferred product for your patient's health plan is Cerezyme. Can the patient's treatment be switched to the preferred product? ❑ Yes, *Please obtain Form for preferred product and submit for corresponding PA* ❑ No

C. Does the patient have a documented inadequate response to treatment with the preferred product, Cerezyme? ***ACTION REQUIRED: If 'Yes', attach supporting chart note(s).*** ❑ Yes, *skip to Criteria Questions* ❑ No

D. Does the patient have a documented intolerable adverse event to the preferred product, Cerezyme? ***ACTION REQUIRED: If 'Yes', attach supporting chart note(s).*** ❑ Yes ❑ No

Criteria Questions:

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 to 3)

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)

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)**

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