JOHNS HOPKINS
HEALTH PLANS

Nexviazyme

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*

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

Criteria Questions:

1. What is the diagnosis?

❒ Late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency) (*If checked, go to 2*)
❒ Other, please specify. _____ (*If checked, go to 2*)

2. Is the request for continuation of therapy with the requested medication?

❒ Yes, *Continue to 3*
❒ No, *Continue to 4*

3. Is the patient responding to therapy (e.g., improvement, stabilization, or slowing of disease progression for motor function, walking capacity, respiratory function, or muscle strength)? ***ACTION REQUIRED***: If yes, supporting chart notes documenting a positive response to therapy (e.g., improvement, stabilization, or slowing of disease progression for motor function, walking capacity, respiratory function, muscle strength) are required.

❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

4. What is the patient's age?

❒ Less than 1 year (*If checked, go to 5*)
❒ 1 year of age or older (*If checked, go to 5*)

5. Was the diagnosis confirmed by enzyme assay demonstrating a deficiency of acid alpha-glucosidase (GAA) enzyme activity OR by genetic testing? ***ACTION REQUIRED***: If yes, attach acid alpha-glucosidase enzyme assay or genetic testing results supporting diagnosis.

❒ Yes, *No Further Questions*
❒ No, *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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