# Xenpozyme

## 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 (POS Code 24)*
❑ *Home (POS Code 12)*
❑ *Off Campus Outpatient Hospital (POS Code 19)*
❑ *On Campus Outpatient Hospital (POS Code 22)*
❑ *Office (POS Code 11)*

**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**

**Criteria Questions:**

1. What is the diagnosis?

❒ Acid sphingomyelinase deficiency (ASMD), *Continue to 2*

❒ Other, please specify. _____, *Continue to 2*

2. Is the patient currently receiving treatment with the requested drug?
❒ Yes, *Continue to 3*
❒ No, *Continue to 4*

3. Has the patient demonstrated a response to therapy (e.g., improvement in lung function, reduction in spleen volume, reduction in liver volume, improvement in platelet count, improvement in linear growth progression)? ***ACTION REQUIRED***: If yes, attach documentation (e.g., chart notes, lab results) of a response to therapy (e.g., improvement in lung function, reduction in spleen volume, reduction in liver volume, improvement in platelet count, improvement in linear growth progression).
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

4. Will the requested drug be used for the treatment of non-CNS manifestations of acid sphingomyelinase deficiency (ASMD)?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Was the diagnosis confirmed by a documented deficiency of acid sphingomyelinase as measured in peripheral leukocytes, cultured fibroblasts, or lymphocytes? ***ACTION REQUIRED***: If yes, attach acid sphingomyelinase enzyme assay results supporting the diagnosis.
❒ Yes, *No Further Questions*
❒ No, *Continue to 6*

6. Was the diagnosis confirmed by genetic testing documenting a mutation in the sphingomyelin phosphodiesterase-1 (SMPD1) gene? ***ACTION REQUIRED***: If yes, attach genetic testing results supporting the 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)**

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