



Elelyso

CareFirst Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518**. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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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*

What is the ICD-10 code? _____

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

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Exception Criteria Questions:

- A. The preferred products for your patient's health plan are Cerezyme and Vpriv. Can the patient's treatment be switched to one of the preferred products?
- ☐ Yes, Cerezyme, *Please obtain Form for preferred product and submit for corresponding PA.*
 - ☐ Yes, Vpriv, *Please obtain Form for preferred product and submit for corresponding PA.*
 - ☐ No, *Continue to Question B*
- B. Did the patient have an inadequate response, contraindication or intolerable adverse event to both preferred products (Cerezyme and Vpriv)? **ACTION REQUIRED: If 'Yes', please attach supporting chart note(s).** ☐ Yes ☐ No
If Yes or No, Continue to Site of Service Questions

Site of Service Questions:

- A. Where will this drug be administered?
- ☐ Ambulatory surgical, *skip to Clinical Criteria Questions*
 - ☐ Home infusion, *skip to Clinical Criteria Questions*
 - ☐ Off-campus Outpatient Hospital, *Continue to B*
 - ☐ On-campus Outpatient Hospital, *Continue to B*
 - ☐ Physician office, *skip to Clinical Criteria Questions*
 - ☐ Pharmacy, *skip to Clinical Criteria Questions*
- B. Is the patient less than 14 years of age?
- ☐ Yes, *skip to Clinical Criteria Questions*
 - ☐ No, *Continue to C*
- C. Is this request to continue previously established treatment with the requested medication? **ACTION REQUIRED: If No, please attach supporting clinical documentation.**
- ☐ Yes - This is a continuation of an existing treatment., *Continue to D*
 - ☐ No - This is a new therapy request (patient has not received requested medication in the last 6 months), *skip to Clinical Criteria Questions*
- D. 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 the infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? **ACTION REQUIRED: If Yes, please attach supporting clinical documentation.**
- ☐ Yes, *skip to Clinical Criteria Questions*
 - ☐ No, *Continue to E*
- E. Does the patient have laboratory confirmed anti-drug-antibodies? **ACTION REQUIRED: If Yes, please attach supporting clinical documentation.**
- ☐ Yes, *skip to Clinical Criteria Questions*
 - ☐ No, *Continue to F*
- F. 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, *Continue to F*
- G. 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, *Continue to G*

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- H. 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, Continue to H
- I. Are **all** alternative infusion sites (pharmacy, physician office, ambulatory care, etc.) **greater than** 30 miles from the patient's home? **ACTION REQUIRED: If Yes, please attach supporting documentation.**
- ☐ Yes, Continue to Clinical Criteria Questions
- ☐ No, Continue to Clinical Criteria Questions

Clinical Criteria Questions

1. What is the diagnosis?

☐ Gaucher disease, Continue to 2

☐ Other, please specify. _____, Continue 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. ACTION REQUIRED: Submit supporting documentation.**

☐ Yes, Continue to 3

☐ No, Continue to 3

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

☐ Type 1, Continue to 4

☐ Type 2, Continue to 4

☐ Type 3, Continue to 4

☐ Other, please specify. _____, Continue to 4

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

☐ Yes, Continue to 5

☐ No, Continue to 6

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

☐ Yes, Continue to 6

☐ No, Continue to 6

6. What is the patient's body weight?

_____ kg, No further questions

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Step Therapy Override: Complete if Applicable for the state of Maryland.	Please Circle	
Is the requested drug being used to treat stage four advanced metastatic cancer?	Yes	No
Is the requested drug's use consistent with the FDA-approved indication or the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage four advanced metastatic cancer and is supported by peer-reviewed medical literature?	Yes	No
Is the requested drug being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Do patient chart notes document the requested drug was ordered with a paid claim at the pharmacy, the pharmacy filled the prescription and delivered to the patient or other documentation that the requested drug was prescribed for the patient in the last 180 days?	Yes	No
Has the prescriber provided proof documented in the patient chart notes that in their opinion the requested drug is effective for the patient's condition?	Yes	No

Step Therapy Override: Complete if Applicable for the state of Virginia.	Please Circle	
Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?	Yes	No
Does the prescribed dose and quantity fall within the FDA-approved labeling or within dosing guidelines found in the compendia of current literature?	Yes	No
Is the request for a brand drug that has an AB-rated generic equivalent or interchangeable biological product available?	Yes	No
Has the patient had a trial and failure of the AB-rated generic equivalent or interchangeable biological product due to an adverse event (examples: rash, nausea, vomiting, anaphylaxis) that is thought to be due to an inactive ingredient?	Yes	No
Is the preferred drug contraindicated?	Yes	No
Is the preferred drug expected to be ineffective based on the known clinical characteristics of the patient and the prescription drug regimen?	Yes	No
Has the patient tried the preferred drug while on their current or previous health benefit plan and it was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?	Yes	No
Is the patient currently receiving a positive therapeutic outcome with the requested drug for their medical condition?	Yes	No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X

Prescriber or Authorized Signature

Date (mm/dd/yy)

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