



Pombiliti

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.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

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:

- | | | |
|--|---------------------------------|---|
| <input type="checkbox"/> Ambulatory Surgical | <input type="checkbox"/> Home | <input type="checkbox"/> Off Campus Outpatient Hospital |
| <input type="checkbox"/> On Campus Outpatient Hospital | <input type="checkbox"/> Office | <input type="checkbox"/> Pharmacy |

What is the ICD-10 code? _____

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. SGM Pombiliti 6204-A, SGM SOC 6222-A – 7/2025.

CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062

Phone: 1-888-877-0518 • Fax: 1-855-330-1720 • www.caremark.com

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, or other pre-medications) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an administration? **ACTION REQUIRED: If Yes, please attach supporting clinical documentation.**
- ☐ Yes, *skip to Clinical Criteria Questions*
 - ☐ No, *Continue to E*
- 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, *Continue to F*
- 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, *Continue to G*
- 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, *Continue to H*
- H. 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*

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Clinical criteria:

1. What is the diagnosis?

☐ Late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency), *Continue to 2*

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

2. Will the requested drug be prescribed by or in consultation with a physician who specializes in the treatment of metabolic disease and/or lysosomal storage disorders?

☐ Yes, *Continue to 3*

☐ No, *Continue to 3*

3. Is this a request for continuation of therapy with the requested medication?

☐ Yes, *Continue to 4*

☐ No, *Continue to 6*

4. 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, attach chart notes documenting a positive response to therapy (e.g., improvement, stabilization, or slowing of disease progression for motor function, walking capacity, respiratory function, or muscle strength).

☐ Yes, *Continue to 5*

☐ No, *Continue to 5*

5. Will the requested medication be taken in combination with Opfolda (miglustat)?

☐ Yes, *No Further Questions*

☐ No, *No Further Questions*

6. Is the patient 18 years of age or older?

☐ Yes, *Continue to 7*

☐ No, *Continue to 7*

7. What is the patient's body weight?

☐ Greater than or equal to 40 kg, *Continue to 8*

☐ Less than 40 kg, *Continue to 8*

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

☐ Yes, *Continue to 9*

☐ No, *Continue to 9*

9. Is the patient improving on current enzyme replacement therapy (ERT) (e.g., Lumizyme, Nexviazyme)?

☐ Yes, *Continue to 10*

☐ No, *Continue to 10*

10. Will the requested medication be taken in combination with Opfolda (miglustat)?

☐ Yes, *No Further Questions*

☐ No, *No Further Questions*

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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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