{{PANUMCODE}}

{{DISPLAY_PAGNAME}}
{{PACDESCRIPTION}}

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to {{COMPANY_NAME}} at {{CLIENT_PAG_FAX}}. Please contact {{COMPANY_NAME}} at {{CLIENT_PAG_PHONE}} with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of {{DRUGNAME}}.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}} **Patient Phone:** <<MEMPHONE>>
Specialty: _____ **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Physician Office Address: <<PHYADDRESS1>> <<PHYADDRESS2>> <<PHYCITY>>, <<PHYSTATE>> <<PHYZIP>>
Drug Name: {{DRUGNAME}}

Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: <<DIAGNOSIS>> **ICD Code**: <<ICD9>>

1. What is the patient's diagnosis?
   ❑ Hypophosphatasia (HPP) ❑ Other _____
2. What is the ICD-10 code? _____
3. What is the patient's:
   A) Height _____in
   B) Weight _____kg
4. What is the weekly prescribed dosage? _____mg/kg
5. When was the onset of the diagnosis?
   ❑ Perinatal/infantile-onset ❑ Juvenile-onset ❑ Adult-onset ❑ Other_____
6. Is the patient currently receiving treatment with the requested medication? ❑ Yes ❑ No *If No, skip to #15*
7. Is the patient currently receiving the requested medication through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #15* ❑ Yes ❑ Unknown ❑ No
8. Is the patient experiencing benefit from therapy as demonstrated by an improvement in skeletal manifestations from baseline as assessed by the Radiographic Global Impressions of Change (RGI-C) scale? ***ACTION REQUIRED: If Yes, please submit medical record of Radiographic Global Impression of Change (RGI-C) scales and no further questions.*** ❑ Yes ❑ No
9. Is the patient less than 18 years of age and is experiencing benefit from therapy as demonstrated by an improvement in height and weight compared to baseline, as measured by z-scores? ***ACTION REQUIRED: If Yes, please submit medical record of height and weight measurements as measured by z-scores and no further questions.*** ❑ Yes ❑ No
10. Is the patient experiencing a benefit from therapy as demonstrated by an improvement in step length by at least 1 point in either foot compared to baseline based on the Modified Performance Oriented Mobility Assessment-Gait (MPOMA-G) scale? ***ACTION REQUIRED: If Yes, please submit medical record of Modified Performance Oriented Mobility Assessment-Gait scores and no further questions.*** ❑ Yes ❑ No
11. Is the patient experiencing benefit from therapy as demonstrated by an improvement in the 6 Minute Walk Test compared to baseline? ***ACTION REQUIRED: If Yes, please submit medical record of distance walked in the 6 Minute Walk Tests and no further questions.*** ❑ Yes ❑ No

12. Is the patient experiencing benefit from therapy as demonstrated by an improvement in the Timed Up & Go (TUG) Test compared to baseline? ***ACTION REQUIRED: If Yes, please submit medical record of Timed Up & Go (TUG) Tests and no further questions.*** ❑ Yes ❑ No

13. Is the patient experiencing benefit from therapy as demonstrated by an improvement in the Chair Rise Test compared to baseline? ***ACTION REQUIRED: If Yes, please submit medical record of Chair Rise Tests and no further questions.*** ❑ Yes ❑ No

14. Is the patient experiencing benefit from therapy as demonstrated by an improvement in the Lower Extremity Function Scale (LEFS) compared to baseline? ***ACTION REQUIRED: If Yes, please submit medical record of Lower Extremity Function Scale (LEFS).*** ❑ Yes ❑ No *No further questions.*

15. Does the patient have documentation of the presence of hypophosphatasia before the age of 18 (e.g., member began experiencing symptoms at age 10)? ***ACTION REQUIRED: If Yes, please submit medical record documentation showing presence of condition before the age of 18.***
    ❑ Yes ❑ No ❑ N/A, patient is not 18 years of age or older

16. Does the patient have clinical signs and/or symptoms of hypophosphatasia (e.g., skeletal abnormalities, respiratory problems, hypercalcemia, seizures)? ❑ Yes ❑ No

17. Did the patient test positive for a known pathological mutation in the ALPL gene as determined by molecular genetic testing? ***ACTION REQUIRED: If Yes, please submit genetic test results.***
    ❑ Yes ❑ No

18. Do findings on radiographic imaging at the time of diagnosis demonstrate skeletal abnormalities and support the diagnosis of hypophosphatasia (e.g., infantile rickets, alveolar bone loss, osteoporosis, low bone mineral content for age [as detected by DEXA])? ***ACTION REQUIRED: If Yes, please submit radiographic imaging results.*** ❑ Yes ❑ No ❑ Not performed

19. How does the patient's pretreatment serum alkaline phosphatase (ALP) level compare to the laboratory's reference normal range based on age and gender? ***ACTION REQUIRED: Please submit laboratory test results.***
    ❑ Higher than the laboratory's normal range
    ❑ Lower than the laboratory's normal range
    ❑ Within the laboratory's normal range

20. Does the patient have an elevated pretreatment substrate level of a tissue-nonspecific alkaline phosphatase (TNSALP) (e.g., serum pyridoxal 5'-phosphate [PLP] level, urine phosphoethanolamine [PEA] level, urinary or plasma inorganic pyrophosphate [PPi level]) as defined by the laboratory performing the test?
    ACTION REQUIRED: If Yes, please submit laboratory test results: a) Radiographic imaging demonstrating skeletal abnormalities, b) A serum alkaline phosphatase level below the gender and age-specific reference range of the laboratory performing the test, and c) Elevated TNSALP substrate level (e.g., serum PLP level, urine PEA level, urinary or plasma PPi level). ❑ Yes ❑ No

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

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Prescriber (Or Authorized) Signature and Date