



## Elaprase

### 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 copy 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

*Please indicate the place of service for the requested drug:*

- Ambulatory Surgical       Home       Off Campus Outpatient Hospital  
 On Campus Outpatient Hospital       Office       Pharmacy

**Clinical Criteria Questions:**

What is the ICD-10 code? \_\_\_\_\_

1. What is the diagnosis?  
 Mucopolysaccharidosis II (MPS II) or Hunter syndrome (If checked, go to 2)  
 Other, please specify. \_\_\_\_\_ (If checked, go to 2)
2. Is this a request for continuation of therapy with the requested medication?  
 Yes (If checked, go to 3)  
 No (If checked, go to 4)

**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. Elaprase SGM 2052-A – 07/2023.

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3. Has the patient experienced a clinically positive response to therapy while receiving the requested drug (e.g., improvement, stabilization, or slowing of disease progression)? ***ACTION REQUIRED:*** If Yes, attach chart notes documenting a clinically positive response to therapy (e.g., improvement, stabilization, or slowing of disease progression).
- Yes (If checked, *no further questions*)
- No (If checked, *no further questions*)
4. Was the diagnosis confirmed by enzyme assay demonstrating a deficiency of iduronate 2-sulfatase enzyme activity OR by genetic testing? ***ACTION REQUIRED:*** If Yes, attach iduronate 2-sulfatase 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 CVS Caremark or the benefit plan sponsor.***

X \_\_\_\_\_  
**Prescriber or Authorized Signature**

\_\_\_\_\_  
**Date (mm/dd/yy)**

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