



## ElELYso

### 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

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

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

**Site of Service Questions:**

- A. Where will this drug be administered?  
 Ambulatory surgical, *skip to Clinical Questions*       Home infusion, *skip to Clinical Questions*  
 Off-campus Outpatient Hospital       On-campus Outpatient Hospital  
 Physician office, *skip to Clinical Questions*       Pharmacy, *skip to Clinical Questions*
- B. Is this request to continue previously established treatment with the requested medication?  
 Yes → This is a continuation of an existing treatment.  
 No → This is a new therapy request (patient has not received requested medication in the last 6 months). *skip to Clinical Criteria Questions*
- C. 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

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

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CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062  
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seizures) during or immediately after an infusion? **ACTION REQUIRED: If Yes, Attach supporting clinical documentation.**  Yes, skip to Clinical Criteria Questions  No

- D. 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, Attach supporting clinical documentation.**

Yes, skip to Clinical Criteria Questions  No

- E. 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, Attach supporting clinical documentation.**

Yes, skip to Clinical Criteria Questions  No

- F. 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, Attach supporting clinical documentation.**

Yes  No

### **Clinical Criteria Questions:**

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

1. What is the diagnosis?

Gaucher disease (If checked, go to 2)

Other, please specify. \_\_\_\_\_ (If checked, go 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.

Yes (If checked, go to 3)

No (If checked, go to 3)

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

Type 1 (If checked, go to 4)

Type 2 (If checked, go to 4)

Type 3 (If checked, go to 4)

Other, please specify. \_\_\_\_\_ (If checked, go to 4)

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

Yes (If checked, go to 5)

No (If checked, go to 6)

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

Yes (If checked, go to 6)

No (If checked, go to 6)

6. What is the patient's body weight?

Less than or equal to 100 kg (220.5 lbs) (If checked, *no further questions*)

Greater than 100 kg (220.5 lbs) (If checked, *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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