Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

CVS caremark™ {{PANUMCODE}}

Galafold

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 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** 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: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the diagnosis?
   ❑ Fabry disease
   ❑ Other _____
2. What is the ICD-10 code? _____
3. Is this a request for continuation of therapy with the requested medication? ❑ Yes ❑ No *If No, skip to #6*
4. Does the patient have an amenable galactosidase alpha gene (GLA) variant? ❑ Yes ❑ No
5. Is the patient responding to therapy e.g., reduction in plasma globotriaosylceramide [GL-3] or GL-3 inclusions)? ❑ Yes ❑ No *No further questions*
6. Was the diagnosis confirmed by enzyme assay demonstrating a deficiency of alpha-galactosidase enzyme activity OR by genetic testing? ***ACTION REQUIRED: If 'Yes', attach alpha- galactosidase enzyme assay or genetic testing results supporting diagnosis and skip to #8.*** ❑ Yes ❑ No
7. Is the patient a symptomatic obligate carrier? ***ACTION REQUIRED: If 'Yes', attach documentation for the parent that is supporting diagnosis.*** ❑ Yes ❑ No
8. Does the patient have an amenable galactosidase alpha gene (GLA) variant based on in vitro assay data? ❑ Yes ❑ No
9. Will the requested medication be given in combination with Fabrazyme? ❑ 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)**

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155