



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: _____ Date: _____
Patient's ID: _____ Patient's Date of Birth: _____
Physician's Name: _____
Specialty: _____ NPI#: _____
Physician Office Telephone: _____ Physician Office Fax: _____
Request Initiated For: _____

- 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, Gb3] or GL-3/Gb3 inclusions, improvement and/or stabilization in renal function, pain reduction)? **ACTION REQUIRED: If Yes, supporting chart notes or lab results must be attached.** Yes No *No further questions.*
- 6. Does the patient have an amenable galactosidase alpha gene (GLA) variant based on in vitro assay data? **ACTION REQUIRED: If Yes, supporting lab results must be attached.** Yes No
- 7. Will the requested medication be given in combination with enzyme replacement therapy (ERT) for the treatment of Fabry disease? 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

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**CVS Caremark Prior Authorization • 1300 E. Campbell Road • Richardson, TX 75081
Phone: 1-866-814-5506 • Fax: 1-866-249-6155 • www.caremark.com**

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