



## Lumizyme

### 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*

**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. Lumizyme SOC SGM – 08/2021.

**CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062**

**Phone: 1-888-877-0518 • Fax: 1-855-330-1720 • www.caremark.com**

**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 seizures) during or immediately after an infusion? ***ACTION REQUIRED: If Yes, Attach supporting clinical documentation.***     Yes, *skip to Clinical Criteria Questions*     No
- D. Does the patient have laboratory confirmed alglucosidase alfa antibodies? ***ACTION REQUIRED: If Yes, Attach supporting clinical documentation.***     Yes, *skip to Clinical Criteria Questions*     No
- E. 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
- F. 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
- G. 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:**

1. What is the diagnosis?  
 Pompe disease (acid alpha-glucosidase [GAA] deficiency)  
 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 #5*
4. Is the patient responding to therapy (e.g., improvement, stabilization, or slowing of disease progression for motor function, walking capacity, cardiorespiratory function, decrease in left ventricular mass index (LVMI), delay in death)?     Yes     No    *No further questions*
5. Was the diagnosis confirmed by enzyme assay demonstrating a deficiency of acid alpha-glucosidase (GAA) enzyme activity OR by genetic testing? ***ACTION REQUIRED: If Yes, attach acid alpha-glucosidase enzyme assay or genetic testing results supporting diagnosis.***     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)**

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