



## Cerezyme and VPRIV Prior Authorization Request

CVS Caremark administers the medical drug prior authorization program on behalf of Harvard Pilgrim Health Care. Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to CVS Caremark, toll-free at 1-844-851-0882** to initiate the review process. If you have questions regarding the prior authorization please contact CVS Caremark at 1-844-387-1435.

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](mailto: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: \_\_\_\_\_ NPI#: \_\_\_\_\_  
Specialty: \_\_\_\_\_ HPHC Provider ID: \_\_\_\_\_  
Physician Office Telephone: \_\_\_\_\_ Physician Office Fax: \_\_\_\_\_

**Rendering Provider Info:**  Same as Requesting Provider HPHC Provider ID: \_\_\_\_\_  
Name: \_\_\_\_\_ NPI#: \_\_\_\_\_  
Fax: \_\_\_\_\_ Phone: \_\_\_\_\_ Provider Tax ID: \_\_\_\_\_

*Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.*

### Additional Demographic Information:

Please indicate the place of service for the requested drug:

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

### Drug Information:

Strength/Measure \_\_\_\_\_ Units  ml  Gm  mg  ea  Un  
Directions(sig) \_\_\_\_\_ Route of administration \_\_\_\_\_  
Dosing frequency \_\_\_\_\_

### Criteria Questions:

1. What is the prescribed drug?  Cerezyme  VPRIV  Other \_\_\_\_\_
2. What is the diagnosis?  
 Gaucher disease  
 Other \_\_\_\_\_
3. What is the ICD-10 code? \_\_\_\_\_
4. 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: Attach results.**  Yes  No
5. Will the prescribed drug be given in combination with substrate reduction therapy (eg, miglustat, eliglustat)?  
 Yes  No
6. Which variant of Gaucher disease does the patient have?  Type 1  Type 2  Type 3  Other \_\_\_\_\_

**Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-844-851-0882**

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. Cerezyme, VPRIV SGM – 04/2018.

CVS Caremark Prior Authorization • 2211 Sanders Road NBT-6 • Northbrook, IL 60062  
Phone: 1-844-387-1435 • Fax: 1-844-851-0882 • [www.caremark.com](http://www.caremark.com)

7. Does the patient have one or more complications of the Type of Gaucher disease, as indicated above?  
 Yes  No
8. Please indicate the disease complication(s). *Indicate all that apply or mark "None of the above."*
- |  |   |
|--|---|
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Hepatomegaly or splenomegaly |
| <input type="checkbox"/> Thrombocytopenia  | <input type="checkbox"/> Developmental delay          |
| <input type="checkbox"/> Bone disease      | <input type="checkbox"/> Ophthalmoplegia (gaze palsy) |
| <input type="checkbox"/> Other(s) _____    |   |
| <input type="checkbox"/> None of the above |   |

***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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