Elelyso

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. 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:** ______________________

<u>Rendering</u> 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.

<u>Additional Demographic Information:</u>

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*

<u>Drug Information:</u>

*Strength/Measure*______________________________ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*__________________________________ *Route of administration*________________________
*Dosing frequency*______________________________

<u>Criteria Questions:</u>

1. What is the diagnosis?
   ❑ Gaucher disease
   ❑ Other ____
2. What is the ICD-10 code? _____________
3. Was the diagnosis of Gaucher disease confirmed by enzyme assay demonstrating a deficiency of beta-glucocerebrosidase (glucosidase) enzyme activity or by genetic testing?
   ACTION REQUIRED: Attach results. ❑ Yes ❑ No
4. Which variant of Gaucher disease does the patient have?
   ❑ Type 1 ❑ Type 2 ❑ Type 3 ❑ Other ____________________________
5. Will Elelyso be given in combination with substrate reduction therapy (eg, miglustat, eliglustat)? ❑ Yes ❑ No

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

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6. Does the patient have one or more complications of Type 1 Gaucher disease?
   If Yes, indicate all that apply or mark "None of the above."
   - ❑ Anemia
   - ❑ Thrombocytopenia
   - ❑ Bone disease
   - ❑ Hepatomegaly or splenomegaly
   - ❑ Other(s) ____
   - ❑ 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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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