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.**

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 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 _____
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."***
   ❑ Anemia
   ❑ Thrombocytopenia
   ❑ Bone disease
   ❑ Hepatomegaly or splenomegaly
   ❑ Developmental delay
   ❑ Ophthalmoplegia (gaze palsy)
   ❑ 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)**

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

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