

Pharmacy Prior Authorization Form

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Fabrazyme® (agalsidase beta) Urgent Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

- Fabrazyme Injection 5.5 mg
 Fabrazyme Injection 37 mg

Dose: _____ Start date: _____

Place of administration:

- Self-administered
 Provider's Office
 Outpatient Infusion Center Name of center: _____
 Home Infusion Name of agency: _____

Billing options:

- Physician buy and bill (J0180)
 Preferred Specialty Vendor
 Other: _____

Priority Health Precertification Requirements:

Authorization of Fabrazyme requires:

- Diagnosis of Fabry disease
- Patient should be receiving antipyretics prior to Fabrazyme infusion

Diagnosis

- Fabry disease based on clinical symptoms or by genetic testing – ICD code: _____
 Other: _____ - ICD code: _____ Please provide rationale for use:

Patient will be receiving antipyretics before the infusion:

- Yes
 No – Rationale for use: _____

Patient's weight: _____

Dosing:

The recommended dosage of Fabrazyme is 1.0 mg/kg body weight infused every 2 weeks.

*** All fields must be complete and legible for Prior Authorization Review***

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX