

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)

Member Name: _____ Member #: _____ - _____

DOB: _____ Sex: _____ Provider Phone: _____

Provider Name: _____ Provider Fax: _____

Provider Office Contact Name: _____ Date: _____

FDA Approved Indication: For use in patients with Fabry disease.

Indicate where the patient will receive infusions:

- Ambulatory Infusion Center
Name of Infusion Center: _____
- Physician's office
- Other: _____

Indicate the dosage requested:

- _____ mg every two weeks
- Other: _____

Priority Health Precertification Requirements:

1. Indication for requested medication:
- Fabry disease based on clinical symptoms or by genetic testing
- Other: _____

Duration of Authorization:

If all precertification requirements are met approval will be granted in one year increments.

Dosing:

The recommended dosage of Fabrazyme is 1.0 mg/kg body weight infused every 2 weeks. Note that patients should receive antipyretics prior to infusion.

For Internal Use Only

Original Date of Req: _____ Non-Urgent: ___ Urgent: ___ Retro: ___ Method: Phone ___ Fax ___ Ltr ___ Coord. Initial ___
Approved: ___ Denied: ___ Letter Type: Denial ___ 48 hr ___ Off-Label Use ___ Verbal: Y ___ N ___ Inquiry number: _____
Product: HMO ___ PPO ___ ASO ___ POS ___ Caid ___ MICHild ___ Mcare ___ McarePlus ___ McareRX ___ McareValue ___ EGMcare ___
Formulary (11/0030/R0) ___ Non-Formulary (11/0032/R0) ___
Dte Addt Info Req _____ by: Phone ___ Fax ___ Dte 48/OL Ltr sent: _____ Dte 2nd 48/OL Ltr Sent (Caid only) _____
Date All Info Recvd _____ Date of Decision to Deny: _____ RPH Initials: _____
Notified: _____ of Denial on: _____ by: Ph ___ Fax ___