

Pharmacy

PRIOR AUTHORIZATION FORM

Last Reviewed: January 2012

Last Updated: March 2010

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 (life threatening)

Non-Urgent (standard review)

A claim involving "urgent care" applies when the standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

Member Information

Member Name:	Member No.:
DOB:	Gender:
Member's PCP:	

Provider Information

Provider Name:	
Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

Provider Signature

Date

PRODUCT INFORMATION

- Fabrazyme 5 mg injection
 Fabrazyme 35 mg injection

Dose: _____

Start Date: _____

Patient's Weight: _____

Dosing: The recommended dosage of Fabrazyme is 1 mg/kg body weight infused every 2 weeks.

BILLING INFORMATION

Place of administration:

- Provider's Office
 Outpatient Infusion Center
Center Name: _____
 Home Infusion
Agency Name: _____

Billing Options:

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

PRIORITY HEALTH PRECERTIFICATION REQUIREMENTS

Authorization for Fabrazyme[®] (agalsidase beta) requires the following information to certify:

Patient must have met the following requirements:

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

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION

Authorization for Fabrazyme[®] (agalsidase beta) requires the following information to certify:

A. What is the patient's diagnosis?

- a. Fabry disease, based on clinical symptoms or genetic testing ICD code: _____
- b. Other: _____
Rationale for use: _____

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

B. Will the patient be receiving antipyretics before the infusion?

- Yes
- No, Rationale for use: _____

PRIORITY MEDICARE PLANS

Note: Priority Health Medicare applies CMS national and local coverage determination criteria when available for Part B drugs. If no national determination criteria or local coverage determination criteria is available for the state in which the member is receiving the services, the above prior authorization criteria must be met.

LCD N/A

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

Please fax this request to: (877)974-4411 toll free or (616)942-8206
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX