PriorityHealth

Medical prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☒ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Elelyso® (Taliglucerase)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Physician: _____ Prov. Phone: _____ Prov. Fax: _____

Physician Address: _____

Physician NPI: _____ Contact Name: _____

Physician Signature: _____ Date: _____

Product and Billing Information

☐ New Request ☐ Continuation Request

Drug product: ☐ Elelyso 200 unit

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Date of next dose (if applicable): _____

Dose:_____ **Dose Frequency**:_____

Place of administration:

☐ Physician's office

☐ Outpatient infusion

Facility: _____ NPI:_____ Fax:_____

☐ Home infusion

Agency: _____ NPI:_____ Fax:_____

Billing:

☐ Physician to buy and bill

☐ Facility to buy and bill

☐ Specialty Pharmacy

Pharmacy:_____ NPI:_____ Fax:_____

ICD-10 Diagnosis code(s): _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following criteria:

1. Diagnosis of Gaucher's Disease, Type 1

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 11/2018

Last reviewed 05/2019

Priority Health Precertification Documentation

A. Is the patient new to this medication, or will this be a continuation in therapy?

☐ Request for new start

☐ Request for continuation, patient has received _____ number of doses to date

B. What condition is this drug being requested for?

☐ Diagnosis of Diagnosis of Gaucher's Disease, Type 1

☐ Other – the patient's condition is: _____

Rationale for use: _____

NOTE: Medicaid members will be required to receive the medication by home infusion after the first 6 doses.

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