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.

Fabrazyme® (agalsidase beta)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Physician: _____ Phys. Phone: _____ Phys. Fax: _____

Physician Address: _____

Physician NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product and Billing Information

☐ New Request ☐ Continuation Request

Drug product:
☐ Fabrazyme 5 mg injection
☐ Fabrazyme 35 mg injection

Dose:_____ **Dose Frequency**:_____
Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Date of next dose: _____

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 Fabry disease
    a. Provide supporting documentation to confirm diagnosis (e.g. alpha-Gal A activity in leukocytes or plasma, mutation analysis of the alpha-Gal A gene)
2. Patient is either:
    a. Classically affected male (i.e. male with very low or undetectable levels of alpha-galactosidase A [alpha-Gal A]), OR
    b. Female carrier or male with atypical presentations (i.e. with marginal levels of alpha-Gal A) with clinical manifestations of Fabry disease (e.g. renal, neurologic, cardiovascular) present
3. Prescribing physician must be a nephrologist, cardiologist, specialist in metabolic disorders or genetics
4. The patient will receive antipyretics before the infusion

If authorized, up to 12 months may be approved.

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 11/2018
Last reviewed 05/2019

For continuation of therapy, the patient must meet all of the following criteria:

1. Continued response to treatment (e.g. reduction in plasma glycosphingolipid GL-3 levels compared to baseline)
2. Compliance with >50 percent of treatments
3. Regularly attends follow-up visits
4. Has not experienced persistent life-threatening or severe infusion reactions that do not respond to prophylaxis (eg, anaphylaxis)
5. Has not developed ESRD, without an option for renal transplantation, in combination with advanced heart failure (New York Heart Association class IV)
6. Does not have end-stage Fabry disease or other comorbidities with a life expectancy of <1 year
7. Has not experienced severe cognitive decline

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.

New Request
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 (please provide documentation to support)?

☐ Fabry disease
☐ Other – the patient's condition is: _____
Rationale for use: _____

C. Will the patient receive antipyretics before the Fabrazyme infusion?

☐ Yes ☐ No

Continuation Request
Priority Health Recertification Documentation

A. Has the patient continued to respond to treatment? (please provide documentation)
☐ Yes ☐ No

B. Has the patient been compliant with therapy and attended follow-up visits?
☐ Yes ☐ No

C. Has the patient experienced persistent life-threatening or severe infusion reactions that do not respond to prophylaxis (eg, anaphylaxis)?
☐ Yes ☐ No

D. Has the patient developed ESRD, without an option for renal transplantation, in combination with advanced heart failure (New York Heart Association class IV)?
☐ Yes ☐ No

E. Does the patient have end-stage Fabry disease or other comorbidities with a life expectancy of <1 year?
☐ Yes ☐ No

F. Has the patient experienced severe cognitive decline?
☐ Yes ☐ No

Additional Information

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

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