

# 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.

## Kanuma<sup>®</sup> (sebelipase alfa)

### Member

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

ID #: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Requesting Provider: \_\_\_\_\_ Prov. Phone: \_\_\_\_\_ Prov. Fax: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Provider NPI: \_\_\_\_\_ Contact Name: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Product and Billing Information

New Request  Continuation Request

Drug product:  Kanuma 2 mg/mL **Start date** (or date of next dose): \_\_\_\_\_

**Date of last dose** (if applicable): \_\_\_\_\_

**Dosing frequency:** \_\_\_\_\_

Place of administration:  Physician's office  
 Outpatient infusion

Facility: \_\_\_\_\_ NPI: \_\_\_\_\_ Fax: \_\_\_\_\_

Home infusion

Facility: \_\_\_\_\_ NPI: \_\_\_\_\_ Fax: \_\_\_\_\_

Billing:  Physician to buy and bill

Facility to buy and bill

Specialty Pharmacy

Pharmacy: \_\_\_\_\_ NPI: \_\_\_\_\_ Fax: \_\_\_\_\_

ICD-10 Diagnosis code(s): \_\_\_\_\_

### Drug cost information

The wholesale acquisition cost for Kanuma is \$10,000 for every 20 mg of drug infused. The cost of treatment with this drug will vary depending on the patient's circumstances, but likely to exceed \$1,000,000 each year.

**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.

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## Precertification Requirements

For this drug to be covered, the patient must have lysosomal acid lipase (LAL) deficiency, confirmed by genetic testing with evidence of a LIPA mutation. Priority Health must receive a copy of the genetic testing results.

1. What condition is this drug requested for?

- Wolman disease
- Cholesteryl ester storage disease (CESD) — later-onset disease
- Other – the patient's condition is: \_\_\_\_\_

Rationale for use: \_\_\_\_\_

PLEASE SEND A COPY OF MUTATION TESTING RESULTS TO PRIORITY HEALTH WITH THIS REQUEST.