PriorityHealth

Pharmacy 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.

Miglustat

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 Information

☐ New request ☐ Continuation request

Drug product: ☐ Miglustat 100 mg capsule

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Drug cost information

The wholesale acquisition cost for miglustat 100 mg capsule is $267.90. The annual cost of treatment with this drug is >$280,000.

Precertification Requirements

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

1. Must be 18 years of age or older; AND
2. Must be using for treatment of mild to moderate type 1 Gaucher disease in patients for whom enzyme replacement therapy is not an option (i.e. because of allergy, hypersensitivity). Must fax documentation of diagnostic testing confirming disease (i.e. Genotype testing) to Priority Health.

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 05/2018

Last reviewed 05/2018

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Type 1 Gaucher disease
- ☐ *Other – the patient's condition is:* _____

Rationale for use: _____

B. Was diagnostic testing faxed to Priority Health?

- ☐ Yes
- ☐ No

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