OPTIMA HEALTH FAMILY CARE

(MEDICAID)

PHARMACY/MEDICAL PRIOR AUTHORIZATION REQUEST

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-844-723-2094**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete form will delay authorization process.**

Drug Requested: **Mepsevii®** (vestronidase alpha-vjbk) **IV (J3590) (Medical)**

DRUG INFORMATION: Complete all information below or authorization process will be delayed.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code, if applicable:** _____

****If approved, the MAXIMUM dose allowed is 4mg/kg to be administered every other week. Continued approval is based on patient maintaining sustained improved walk time above baseline walk time and evidence of clinical improvement. Yearly reauthorization is required.****

CLINICAL CRITERIA: All boxes **MUST** be checked to ensure authorization process will **NOT** be delayed.

For Initial 12 Month Approval - All of the following criteria must be met:

- ❑ Prescriber must be a metabolic geneticist or endocrinologist
- ❑ The patient must be aged 5 months to 25 years
- ❑ The patient must have a diagnosis of mucopolysaccharidosis type VII (MPS VII or Sly syndrome) as verified by genetic testing or leukocyte or fibroblast glucuronidase enzyme assay **(labs confirming diagnosis must be submitted)**
- ❑ Patient's current height **(please note)**: _____ Patient's current weight **(please note)**: _____
- ❑ Current FVC **(please submit labs)**: _____
- ❑ Patient's current normalized urine glycosaminoglycan levels **(please submit labs)**: _____
- ❑ Baseline 6 minute walk time is attached **(please attach current baseline 6 minute walk time with date noted)**
- ❑ Chart notes must be attached to document symptoms, prior medical procedures and/or prior therapies used in the treatment of MPS VII **(please attach chart notes)**

For Continued 12 Month Approval - All of the following criteria must be met:

- ❑ Current 6 minute walk time is attached **(please attach current 6 minute walk time with date noted)**
- ❑ The patient's 6 minute walk time must document sustained improvement from baseline
- ❑ Patient's current height **(please note)**: _____ Patient's current weight **(please note)**: _____

(Continued on next page)

- ❑ Current FVC **(please submit labs)**: _____
- ❑ Patient's current normalized urine glycosaminoglycan levels must have decreased from baseline **(please submit labs)**: _____
- ❑ Chart notes must be attached to document current disease status, any medical procedures performed since last approval of this medication, and evidence of clinical improvement from baseline **(please attach chart notes)**

Medication being provided by (please check applicable box(es) below):

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

  OR

- ❑ **Specialty Pharmacy - PropriumRx**

Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee**: 3/15/2018
REVISED/UPDATED: ~~7/17/2018;~~ ~~8/27/2018;~~ ~~10/8/2018;~~ **(Reformatted) 2/5/2019**;