

**OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)**

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT 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 1-844-348-3720.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete form will delay the authorization process.**

Drug Requested: **Vimizim® IV** (elosulfase alfa) (J1322) **(Medical)**

****IV INFUSION PERFORMED AT SENTARA INFUSION CENTERS ONLY****

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

Drug Form/Strength/Month: _____

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

Diagnosis: _____ **ICD Code:** _____

****If approved, max dose allowed is 2mg/kg to be administered once weekly.**

CLINICAL CRITERIA: Check **ALL** boxes that apply to ensure authorization process will **NOT** be delayed.

- Due to high risk of anaphylaxis and infusion reactions, Vimizim® infusion should be administered **ONLY** by trained medical professionals and will **NOT** be approved for self-administration or for administration by home healthcare providers.

For Initial Approval: **Initial approval will be for 24 weeks.** CHART NOTES, LAB RESULTS **MUST** BE SUBMITTED **WITHIN THE LAST 30 DAYS.** **ALL** criteria **MUST** be met for approval.

- The prescriber is a metabolic geneticist or endocrinologist

AND

- The patient is at least 5 years of age

AND

- The patient has a diagnosis of mucopolysaccharidosis type IVA (MPS IVA) as verified by genetic testing (**labs confirming diagnosis must be submitted**)

AND

- Patient's current height (please note): _____ Patient's current weight (please note): _____

AND

Current FEV1 (**please submit labs**): _____ Current MVV (**please submit lab results within the last 30 days**): _____

AND

(continued on next page)

- Patient's current normalized urine keratan sulfate levels (**please submit lab results within the last 30 days**):

AND

- Baseline 6 minute walk time of a distance of **at least** 30 meters is attached (**please attach baseline 6 minute walk time with date noted**)

AND

- Chart notes are attached to document symptoms, prior medical procedures, and prior therapies used in the treatment of MPS IVA

AND

For Continued Approval: Continued approval will be based on patient maintaining sustained improved walk time above baseline walk time and evidence of clinical improvement.
Continued approval is for 12 months.

- Current 6 minute walk time of one **within the last 30 days** is attached (**please attach current 6 minute walk time with date noted**):

AND

- Patient's 6 minute walk time has sustained improvement from baseline

AND

- Patient's current height (**please note**): _____ Patient's current weight (**please note**): _____

AND

Current FEV₁ (**please submit labs within last 30 days**): _____

Current MVV (**please submit labs within the last 30 days**): _____

AND

- Patient's current normalized urine keratan sulfate levels (**please submit labs within the last 30 days**): _____

AND

- Chart notes are 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 the following:

- Location/site of administration: _____

NPI or DEA # of administering location: _____

OR

- Specialty Pharmacy - PropriumRx

(Continued on next page; signature page **MUST** be attached to this request.)

(Signature page **MUST** be included with this request.)

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: _____
Prescriber's DEA OR NPI #: _____

*Approved by Pharmacy and Therapeutics Committee: 4/19/2018
REVISED/UPDATED: 6/30/2018; 8/31/2018; 10/8/2018