OPTIMA HEALTH FAMILY CARE
(MEDICAID)

PHARMACY/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 1-844-723-2094**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct**.** **Incomplete form will delay 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 FEV_1 **(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;~~ **(REFORMATTED) 2/5/2019**