

OPTIMA HEALTH COMMUNITY CARE

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

- 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

(continued on next page)

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

*****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