OPTIMA HEALTH PLAN

MEDICAL/PHARMACY 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 1-844-202-5034. 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)**

***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* applicable boxes to ensure authorization 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 FEV_1 ***(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 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 – Briova SpecialtyRx**

*****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: 7/10/2018