

## Cerdelga® Prior Authorization Request Form (Page 1 of 2)

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Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information <small>(required)</small>			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>		Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>			

Clinical Information <small>(required)</small>	
<b>Select the diagnosis below:</b>	
<input type="checkbox"/> Gaucher disease type 1	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	

<p><b>Clinical Information:</b></p> <p>Is the prescriber a metabolic geneticist or physician knowledgeable in the management of Gaucher disease? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b></p> <p>Select if the patient has Gaucher disease type 1 as confirmed by the following:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Glucocerebrosidase activity less than or equal to 30% of normal activity in the white blood cells or skin fibroblasts</li> <li><input type="checkbox"/> Genotype testing indicates mutation of two alleles of the glucocerebrosidase genome</li> </ul> <p><i>Lab test or genetic test results must be submitted</i></p> <p>Is the patient a CYP2D6 extensive metabolizer (EM), intermediate metabolizer (IM), or poor metabolizer (PM) as confirmed by a FDA-approved genotype test? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b></p> <p><i>Lab results must be attached</i></p> <p>Select if the patient presents with the following:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Clinically significant splenomegaly (spleen volume ≥ 10 times normal) as confirmed by medical imaging such as volumetric magnetic resonance imaging (MRI)</li> <li><input type="checkbox"/> Clinically significant hepatomegaly (liver volume ≥ 1.5 times normal) as confirmed by medical imaging such as volumetric MRI</li> <li><input type="checkbox"/> Hemoglobin ≤ 11 g/dL for females and ≤ 12 g/dL for males, or 1.0 g/dL below lower limit for normal for age and sex</li> <li><input type="checkbox"/> Platelet count ≤ 120,000/mcL</li> <li><input type="checkbox"/> Evidence of bone disease, such as avascular necrosis, osteopenia, pathological fracture, Erlenmeyer flask deformity, osteosclerosis or radiological evidence of joint deterioration, that is not attributed to another condition or diagnosis</li> </ul> <p><i>Labs or diagnostics must be submitted for documentation</i></p> <p>Will Cerdelga be used in combination with Cerezyme, Vpriv, Elelyso, Zavesca or other enzyme replacement or substrate-reducing therapy for treatment of Gaucher disease? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b></p> <p>Does the patient have moderate renal impairment, severe renal impairment, or end-stage renal disease (ESRD)? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b></p> <p>Does the patient have mild, moderate, or severe hepatic impairment or cirrhosis? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b></p> <p>Has the patient had partial or total splenectomy within the last 3 years? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b></p> <p>Does the patient have pre-existing cardiac disease or long QT syndrome? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b></p> <p>Is the patient an ultra-rapid or indeterminate CYP2D6 metabolizer? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b></p> <p>Does the patient have Gaucher disease type 2 or 3? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b></p> <p>Select if the patient is one of the following:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> CYP2D6 poor metabolizer (PM)</li> <li><input type="checkbox"/> CYP2D6 extensive metabolizer (EM) or intermediate (IM)</li> </ul>
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**Reauthorization:**

**If this is a reauthorization, answer the following:**

Has the patient's spleen volume decreased by  $\geq 15\%$  from baseline?  Yes  No

Has the patient's liver spleen decreased from baseline?  Yes  No

Has the patient's hemoglobin level increased by  $\geq 0.5$  g/dL from baseline or has remained stable at baseline level?  Yes  No

Has the patient's platelet count increased by  $\geq 15\%$  from baseline?  Yes  No

Will Cerdelga be used in combination with Cerezyme, Vpriv, Eleyso, Zavesca or other enzyme replacement or substrate-reducing therapy for treatment of Gaucher disease?  Yes  No

**\*\*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.\***

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.  
For urgent or expedited requests please call 1-800-711-4555.  
This form may be used for non-urgent requests and faxed to 1-800-527-0531.