Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

Elelyso (FA-PA)

This fax machine is located in a secure location as required by HIPAA regulations.

Complete/review information, sign and date. Fax signed forms to CVS/Caremark at 1-888-836-0730.

Please contact CVS/Caremark at 1-855-240-0536 with questions regarding the prior authorization process.

When conditions are met, we will authorize the coverage of Elelyso (FA-PA).

Drug	g Name (select from lis	st of drugs shown)		
Elel	lyso (taliglucerase alfa))		
Qua	ntity	Frequency	Strength	
Route of Administration		Expected Length o	· ·	
Patie	ent Information			
Patie	ent Name:			
Patie	ent ID:		-	
Patie	ent Group No.:		-	
	ent DOB:		-	
Patie	ent Phone:		-	
	scribing Physician			
Phys	sician Name:		-	
Phys	sician Phone:		_	
Phys	sician Fax:		_	
Phys	sician Address:		_	
City	, State, Zip:		<u>-</u>	
Diagnosis:		ICD Code:	<u> </u>	
_		_		
Con	nments:			
Diago	oo oirolo tha annronriata a	nowar for each guestion		
	se circle the appropriate a	-		
1.		ets for your patient's health plan are elga. Can the patient's treatment be	YN	
	switched to Cerezyme			
2.		ntinuation of therapy with the	YN	
	requested product?	μ,		
3.	Is the patient currently receiving the requested product		YN	
	through samples or a manufacturer's patient assistance			
	program? If unknown	, answer 'Yes'.		
4.	•	a documented inadequate response	Y N	
	OR a documented ad	dverse event to treatment with BOTH		

	the preferred products (Cerezyme and Cerdelga)? ACTION REQUIRED: IF 'YES', ATTACH SUPPORTING CHART NOTE(S).		
5.	Has the patient experienced a documented inadequate response OR a documented intolerable adverse event to the preferred product Cerezyme? ACTION REQUIRED: IF 'YES', ATTACH SUPPORTING CHART NOTE(S).	YN	
6.	Is the patient an indeterminate or ultra-rapid CYP2D6 metabolizer?	YN	
7.	Does the patient have pre-existing cardiac, renal, or hepatic disease?	YN	
8.	Does the patient have a clinically significant drug interaction with the preferred product (Cerdelga)?	YN	

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date	