



Cerezyme

HMSACOM - Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-237-5512.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414**. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Patient's Phone Number: _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Patient Weight: _____ *kg*
Patient Height: _____ *ft* _____ *inches*

Indicate where the drug is being dispensed:

- Office Outpatient Hospital Ambulatory Surgical Inpatient Hospital
- Off Campus Outpatient Hospital Urgent Care Emergency Room Birthing Center
- Military Facility Skilled Nursing Facility Nursing Facility Hospice
- Inpatient Psychiatric Psychiatric Residential Treatment End Stage Renal Facility
- Psychiatric Facility Pharmacy Other

Indicate where the drug is being administered:

- Ambulatory surgical Home Inpatient Hospital
- Office Outpatient Hospital Pharmacy

What is the ICD-10 code? _____

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Cerezyme HMSACOM C11102-A – 11/2024.

CVS Caremark Specialty Programs • 2969 Mapunapuna Place • Honolulu, HI 96819
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Criteria Questions:

1. What is the diagnosis?

Gaucher disease, *Continue to #2*

Other, *Continue to #2*

2. Which variant of Gaucher disease does the patient have?

Type 1, *Continue to #3*

Type 2, *Continue to #3*

Type 3, *Continue to #3*

Other, *Continue to #3*

3. Was the diagnosis of Gaucher disease confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase (glucosidase) enzyme activity or by genetic testing? ***ACTION REQUIRED: Submit results of enzyme assay or DNA testing***

Yes, *Continue to #4*

No, *Continue to #4*

4. Is the request for continuation of therapy?

Yes, *Continue to #5*

No, *Continue to #100*

5. Is the patient experiencing an inadequate response or any intolerable adverse events from therapy with Cerezyme?

Yes, *Continue to #100*

No, *Continue to #100*

Quantity Limits

100. What is the patient's body weight?

100 kg (220.5 lbs) or less, *No Further Questions*

Greater than 100 kg (220.5 lbs) , *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X _____

Prescriber or Authorized Signature

Date (mm/dd/yy)

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