



VPRIV

HMSA - 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*

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. VPRIV HMSA – 11/2022.

**CVS Caremark Specialty Programs • 2969 Mapunapuna Place • Honolulu, HI 96819
Phone: 1-808-254-4414 • Fax: 1-866-237-5512 • www.caremark.com**

Criteria Questions:

1. ***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

2. ***Indicate where the drug is being administered:***

- Ambulatory surgical Home Inpatient Hospital
- Office Outpatient Hospital Pharmacy

3. What is the diagnosis?

- Gaucher disease Other _____

4. What is the ICD-10 code? _____

5. 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: Please attach results of enzyme assay or genetic testing.*** Yes No

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

- Type Type 2 Type 3 Other _____

7. Is this request for continuation of therapy with VPRIV? Yes No *If No, no further questions*

8. Is the patient experiencing an inadequate response or any intolerable adverse events from therapy with VPRIV? Yes No

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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