



## Vimizim

### 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.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to [do\\_not\\_call@cvscaremark.com](mailto:do_not_call@cvscaremark.com). An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

**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

#### Criteria Questions:

- 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 diagnosis?  
 Mucopolysaccharidosis IVA (MPS IVA or Morquio A syndrome)  
 Other \_\_\_\_\_
- What is the ICD-10 code? \_\_\_\_\_
- Is this a request for continuation of therapy with the requested medication?  Yes  No *If no, skip to #7*
- Has the patient experienced a clinically positive response to therapy while receiving Vimizim (e.g., improvement, stabilization, or slowing of disease progression)? **Action Required: Attach chart notes documenting a clinically positive response to therapy.**  Yes  No *No Further Questions*

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

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

7. Was the diagnosis confirmed by enzyme assay demonstrating a deficiency in N-acetylgalactosamine 6-sulfatase enzyme activity OR by genetic testing? ***Action Required: If 'Yes', please attach results of enzyme assay or genetic testing.***  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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