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.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
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.

1. Indicate where the drug is being administered:
   ❑ Ambulatory surgical ❑ Home ❑ Inpatient hospital ❑ Office ❑ Outpatient treatment center ❑ Pharmacy
2. What is the diagnosis? ❑ Gaucher disease ❑ Other _____
3. What is the ICD-10 code? _____
4. Which variant of Gaucher disease does the member have? ❑ Type 1 ❑ Type 2 ❑ Type 3
5. Is this request for a new start or a continuation of VPRIV therapy?
   If New start, skip to #9 ❑ New start ❑ Continuation
6. Was VPRIV previously authorized by HMSA/CVS for this member? ❑ Yes ❑ No *If No, skip to #9*
7. Was previous authorization confirmed by review of either claims history or prior authorization history?
   ❑ Yes ❑ No *If No, skip to #9*
8. Is there evidence of benefit from VPRIV therapy? ❑ Yes ❑ No *No further questions*
9. Is the prescribed agent given in combination with Zavesca or Cerdelga? ❑ Yes ❑ No
10. Was the diagnosis of Gaucher disease confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase (glucosidase) enzyme activity or by DNA testing? ***Action Required*: Please attach results of enzyme assay or DNA testing.** ❑ Yes ❑ No
11. Indicate which complications of Type 1 Gaucher disease the member has? *Indicate any/all that apply*
    ❑ Anemia, *no further questions* ❑ Hepatomegaly or splenomegaly, *no further questions*
    ❑ Thrombocytopenia, *no further questions* ❑ Bone disease, *no further questions*
    ❑ Other _____ ❑ None
12. Does the clinician consider the complication(s) to be appropriate for approval? ❑ 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)**

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

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