HIGHMARK HEALTH OPTIONS

Updated: 06/2025
DMMA Approved: 06/2025

Request for Prior Authorization for Pulmozyme (recombinant dornase alfa)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Pulmozyme (recombinant dornase alfa) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Pulmozyme (recombinant dornase alfa) Prior Authorization Criteria:

Coverage may be provided with a diagnosis of **Cystic Fibrosis (CF)** and the following criteria is met:

- Must be 3 months of age or older
- Must be prescribed by or in association with a pulmonologist/cystic fibrosis specialist
- Must meet ONE of the following criteria:
  - Age less than 12
  - Not currently taking Trikafta (elexadaftor/tezacaftor/ivacaftor) or Alyftrek (vanzacaftor/tezacaftor/deuticaftor)
  - Age ≥ 12 taking Trikafta or Alyftrek with moderate to severe lung disease (i.e. FEV ≤ 70)
- Will be used in conjunction with standard cystic fibrosis therapies [(e.g. oral, inhaled, and/or parenteral antibiotics; inhaled hypertonic saline; chest physiotherapy; bronchodilators; enzyme supplements/vitamins; oral or inhaled corticosteroids; other anti-inflammatory therapy (e.g. ibuprofen)]
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines.
- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**
  - Must continue to meet all initial criteria above
  - Improvement in symptoms
  - Decreased number of pulmonary infections and/or exacerbations
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

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PULMOZYME (DORNASE ALFA) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (855) 476-4158**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (844) 325-6251 Mon – Fri 8 am to 7 pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:
Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:

For age 12 and older: Is Trikafta or Alytrek currently being used?
☐ Yes – what is the current severity of lung disease? ☐ mild (FEV > 70) ☐ moderate-severe (FEV ≤ 70)
☐ No

Will Pulmozyme be used in conjunction with standard cystic fibrosis therapies (e.g., inhaled saline, physiotherapy, bronchodilators, antibiotics, corticosteroids, anti-inflammatory agents)? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member experienced improvement with treatment? ☐ Yes ☐ No

For age 12 and older: Is Trikafta or Alytrek currently being used?
☐ Yes – what is the current severity of lung disease? ☐ mild (FEV > 70) ☐ moderate-severe (FEV ≤ 70)
☐ No

Will Pulmozyme be used in conjunction with standard cystic fibrosis therapies (e.g., inhaled saline, physiotherapy, bronchodilators, antibiotics, corticosteroids, anti-inflammatory agents)? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date