Updated: 06/2020
DMMA Approved: 06/2020

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

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

Vimizim (elosulfase alfa) Prior Authorization Criteria:

Coverage may be provided with a diagnosis of Mucopolysaccharidosis type IVA (MPS IVA Morquio A syndrome) and the following criteria is met:

- Member is 5 years of age or older.
- The diagnosis has been confirmed by biochemical/genetic confirmation by ONE of the following:
  - Absence or marked reduction in N-acetylgalactosamine 6-sulfatase (GALNS) enzyme activity.
  - Sequence analysis and/or deletion/duplication analysis of the GALNS gene for biallelic mutation.
- The medication is prescribed by a by or in association with a biochemical geneticist or metabolic physician.
- 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**
  - Reauthorization benefit will be approved if there is documented, significant improvement with prior courses with treatment.
- **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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Vimizim (elosulfase 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 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

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

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
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 (if medically please provide a 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)

1. Is member 5 years of age or older? ☐ Yes ☐ No

2. Has the diagnosis been confirmed by biochemical/genetic confirmation by ONE of the following

   a. Absence of marked reduction in N-acetylgalactosamine 6-sulfate (GALNS) enzyme activity
   ☐ Yes ☐ No

   b. Sequence analysis and/or deletion/duplications analysis of the GALNS gene for biallelic mutation
   ☐ Yes ☐ No

3. Has the medication been prescribed by or in association with a biochemical geneticist or metabolic physician?
   ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

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

REAUTHORIZATION

Has there been documented, significant improvement with prior courses with treatment?

☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date