HIGHMARK HEALTH OPTIONS

Updated: 07/2025
Approved: 07/2025

Request for Prior Authorization for Enzyme Replacement Therapy, Pompe Disease
Website Form – www.wv.highmarkhealthoptions.com
Submit request via: Fax - 1-833-547-2030.

All requests for Enzyme Replacement Therapy, Pompe Disease require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Enzyme Replacement Therapy, Pompe Disease medications include Lumizyme (alglucosidase alfa) and Nexviazyme (avalglucosidase alfa-ngpt). New products with this classification will require the same documentation.

Enzyme Replacement Therapy, Pompe Disease Prior Authorization Criteria:

Coverage may be provided with a diagnosis of **Pompe Disease** and the following criteria is met:

- Documentation of diagnosis of Pompe Disease (GAA deficiency) confirmed by ONE of the following:
  - Deficiency of acid alpha-glucosidase enzyme activity OR
  - Detection of pathogenic variants in the GAA gene by molecular genetic testing
- Must be age-appropriate according to FDA-approved labeling, nationally recognized compendia, or evidence-based practice guidelines
- Medication must be prescribed by or in consultation with a metabolic specialist and/or biochemical geneticist.
- Documentation of baseline values for one or more of the following:
  - Infantile-onset disease: muscle weakness, motor function, respiratory function, cardiac involvement, percent predicted forced vital capacity (FVC) OR
  - Late-onset (non-infantile) disease: percent predicted forced vital capacity (FVC), walking distance or 6-minute walk test (6MWT) or gastrointestinal symptoms
    - Note: 6MWT excluded for members at an age not able to walk
- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**
  - Documentation the member demonstrates a clinical benefit to therapy compared to pre-treatment baseline in one or more of the following:
    - Infantile-onset disease: stabilization or improvement in muscle weakness, motor function, respiratory function, cardiac involvement, or FVC OR
    - Late-onset (non-infantile) disease: stabilization or improvement in FVC and/or 6MWT and signs/symptoms of the condition
- **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.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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ENZYME REPLACEMENT THERAPY, POMPE DISEASE
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: (833)-547-2030.**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: 1-844-325-6251 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: ☐ Infantile-onset Pompe disease ☐ Late-onset (non-infantile) Pompe disease ICD-10: _____
Does the member have confirmed testing of deficiency of acid alpha-glucosidase enzyme activity OR detection of pathogenic variants in the GAA gene by molecular genetic testing? ☐ Yes ☐ No
For infantile-onset disease: does the member have documented baseline values for one or more of the following: muscle weakness, motor function, respiratory function, cardiac involvement, percent predicted forced vital capacity (FVC)?
☐ Yes ☐ No
For late-onset (non-infantile) disease: does the member have documented baseline values for one or more of the following: percent predicted forced vital capacity (FVC), walking distance or 6-minute walk test (6MWT) or gastrointestinal symptoms? ☐Yes ☐ No

CURRENT or PREVIOUS THERAPY

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

REAUTHORIZATION

Please indicate which of the following apply as a result of treatment:
☐ For infantile-onset disease: Is there an improvement from the members baseline values for one or more of the following: muscle weakness, motor function, respiratory function, cardiac involvement, percent predicted forced vital capacity (FVC)? ☐Yes ☐ No
☐ For late-onset (non-infantile) disease: Is there an improvement from the members baseline values for one or more of the following: percent predicted forced vital capacity (FVC), walking distance or 6-minute walk test (6MWT) or gastrointestinal symptoms? ☐Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date

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This page is only to be used if the form extends to a second page.

DRUG NAME

PRIOR AUTHORIZATION FORM (CONTINUED) – PAGE 2 OF 2

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MEMBER INFORMATION

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

MEDICAL HISTORY (Complete for ALL requests)

*****Fill in questions as needed****** If you add content to this section that increases the request form to two pages, please have a section on page two that identifies which member the request is being submitted.

☐

☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

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

REAUTHORIZATION

Add questions as needed

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

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date