



Updated: 09/2020  
DMMA Approved: 09/2020

**Request for Prior Authorization for Lumizyme (alglucosidase alfa)**

**Website Form – [www.highmarkhealthoptions.com](http://www.highmarkhealthoptions.com)**

**Submit request via: Fax - 1-855-476-4158**

All requests for Lumizyme (alglucosidase alfa) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

**Lumizyme (alglucosidase alfa) Prior Authorization Criteria:**

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

- Must be prescribed by or in consultation with a metabolic specialist and/or biochemical geneticist.
- Must have GAA assay performed on dried blood spots, skin fibroblasts or muscle biopsy.
- For members 12 years and older, must have pulmonary function testing (PFT) and muscle strength evaluation with documentation of baseline percent predicted forced vital capacity (FVC) and baseline 6-minute walk test.
- For late-onset Pompe disease only, must have completed genetic testing to identify the specific mutation to confirm the diagnosis of late-onset Pompe disease.
- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**
  - For members 12 years of age or older, clinical documentation of improvement defined by improvement in percent predicted FVC and/or 6-minute walk test compared to baseline.
  - For members under the age of 12, reauthorization benefit will be approved if there is documented, significant improvement with prior courses of treatment.
- **Reauthorization Duration of approval:** 12 months

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.

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.

**LUMIZYME (ALGLUCOSIDASE 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**Billing Information**

This medication will be billed: <input type="checkbox"/> at a pharmacy <b>OR</b> <input type="checkbox"/> medically (if medically please provide a JCODE: _____)	
Place of Service: <input type="checkbox"/> Hospital <input type="checkbox"/> Provider's office <input type="checkbox"/> Member's home <input type="checkbox"/> Other	

**Place of Service Information**

Name:	NPI:
Address:	Phone:

**MEDICAL HISTORY (Complete for ALL requests)**

Diagnosis: <input type="checkbox"/> Infantile-onset Pompe disease <input type="checkbox"/> Late-onset (non-infantile) Pompe disease ICD-10: _____ <input type="checkbox"/> Other: _____ ICD-10: _____
Was diagnosis confirmed by GAA assay performed on dried blood spots, skin fibroblasts or muscle biopsy? <input type="checkbox"/> Yes <input type="checkbox"/> No
For late-onset Pompe disease, was genetic testing done to confirm the diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has baseline pulmonary function testing (PFT) and muscle strength evaluation been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No

**REAUTHORIZATION**

Please indicate which of the following apply as a result of treatment:	
<input type="checkbox"/> Improvement in FVC: Baseline: _____ Date: _____ Recent FVC: _____ Date: _____	
<input type="checkbox"/> Improvement in 6-min walk or other muscle strength evaluation: Baseline: _____ Date: _____ Recent 6-min walk: _____ Date: _____	
<input type="checkbox"/> Other improvements (please describe or attach chart documentation): _____	

**SUPPORTING INFORMATION or CLINICAL RATIONALE**

<b>Prescribing Provider Signature</b>	<b>Date</b>