HIGHMARK HEALTH OPTIONS

Updated: 08/2025
Approved: 08/2025

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

All requests for Gaucher Disease: Enzyme Replacement Therapy require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Gaucher Disease: Enzyme Replacement Therapy Prior Authorization Criteria:

ERT includes Cerezyme (imiglucerase), Elelyso (taliglucerase alfa), Vpriv (velaglucerase alfa). New products with this classification will require the same documentation.

Coverage may be provided with a diagnosis of Type 1 Gaucher Disease and the following criteria is met:

- Confirmation of Type 1 Gaucher Disease diagnosis by one of the following:
  - A beta-glucosidase leukocyte (BGL) test
  - A genetic test
- Is age appropriate according to FDA approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- Member must also have one or more of the following (supported by the corresponding documentation):
  - Anemia
    - Documentation of a baseline low hemoglobin level (laboratory reference range must be submitted)
  - Thrombocytopenia
    - Documentation of a baseline low platelet level (laboratory reference range must be submitted)
  - A provider attestation that the member has one of the following:
    - Bone Disease
    - Hepatomegaly or splenomegaly supported by documentation of a current baseline liver or spleen size
- **Initial Duration of Approval:** 6 months

- **Reauthorization criteria**:
  - Documentation the member had a positive clinical response or stabilization as demonstrated by one of the following:
    - An increase in hemoglobin level from baseline (taken within last 6 months)
    - An increase in platelet levels from baseline (taken within last 6 months)
    - An attestation from the provider of an improvement in bone disease
    - A reduction in liver or spleen size from baseline (taken yearly)

- **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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GAUCHER DISEASE ENZYME REPLACEMENT THERAPY 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:	ICD Code:

If requesting for Type 1 Gaucher Disease how was the diagnosis confirmed? *Please provide supporting documentation* ☐ Beta-glucosidase leukocyte (BGL) test ☐ Genetic Testing

Does the member have any of the following: *please select all that apply*

☐ Anemia
☐ Thrombocytopenia
☐ Bone Disease
☐ Hepatomegaly or splenomegaly

Please provide the following and laboratory reference range

Baseline hemoglobin level: _____ Date taken: _____
Baseline platelet level: _____ Date taken: _____
Baseline spleen size:_____ Date taken: _____
Baseline liver size _____ Date taken: _____

CURRENT or PREVIOUS THERAPY

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

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GAUCHER DISEASE ENZYME REPLACEMENT THERAPY
PRIOR AUTHORIZATION FORM (CONTINUED) – PAGE 2 OF 2

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MEMBER INFORMATION

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

REAUTHORIZATION

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

If the member has bone disease has the member shown improvement ☐ Yes ☐ No ☐N/A

Please provide the following and laboratory reference range

Current hemoglobin level: _____ Date taken: _____
Current platelet level: _____ Date taken: _____
Current spleen size:_____ Date taken: _____
Current liver size _____ Date taken: _____

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date