Updated: 06/2024
PARP Approved: 07/2024

Prior Authorization Criteria

Pulmozyme (dornase alfa)

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

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

- Must be 3 months of age or older
- Must be prescribed by or in association with a pulmonologist or cystic fibrosis specialist
- 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**
    - Member is receiving clinical benefit based on the prescriber's assessment
- **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.

HIGHMARK WHOLECARE

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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 Wholecare Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (800) 392-1147 Mon – Fri 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	Provider NPI:
Provider Specialty:	Office Contact:
State license #:	Office NPI:
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:	

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:

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

Please indicate which of the following apply:

☐ Improvement in symptoms
☐ Decreased number of pulmonary infections and/or exacerbations

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date