Lamzede® (velmanase alfa-tycv) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021 (TTY: 711)
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy, Date of last treatment ____/____/____

Precertification Requested By: ____________ Phone: ________ Fax: ________

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:

Patient Current Weight: ____ lbs or ____ kgs Patient Height: ____ inches or ____ cms | Allergies:

B. INSURANCE INFORMATION

Aetna Member ID #: __________
Group #: __________
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: ________ Carrier Name: ________
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name:	*(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.		
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one)*: ☐ **Endocrinologist** ☐ **Other**: __________

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:

☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: ________
Center Name: ________
☐ Home Infusion Center Phone: ________
Agency Name: ________
☐ Administration code(s) (CPT): ________
Address: ________

Dispensing Provider/Pharmacy: *Patient Selected choice*

☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other
Name: ________
Address: ________
Phone: ________ Fax: ________
TIN: ________ PIN: ________

E. PRODUCT INFORMATION

Request is for: Lamzede (velmanase alfa-tycv) Dose: ________ **Frequency:** ________

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: ________ **Secondary ICD Code:** ________ **Other ICD Code:** ________

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (clinical documentation required):

☐ Yes ☐ No Is this infusion request in an outpatient hospital setting?

→ ☐ Yes ☐ No Has the patient experienced an adverse event with the requested product that has not responded to conventional intervention (e.g., acetaminophen, steroids, diphenhydramine, fluids, other pre-medications, or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?

☐ Yes ☐ No Has the patient developed laboratory confirmed anti-velmanase alfa-tycv antibodies which increases the risk for infusion related reactions?

☐ Yes ☐ No Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?

☐ Yes ☐ No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of infusion therapy AND the patient does not have access to a caregiver?

→ Please provide a description of the behavioral issue or impairment: ________

☐ Yes ☐ No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the patient's ability to tolerate a large volume or load or predispose the patient to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?

→ Please provide a description of the condition: ☐ Cardiovascular: ________
☐ Respiratory: ________
☐ Renal: ________
☐ Other: ________

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

For Initiation Requests (clinical documentation required for all requests):

☐ Yes ☐ No Does the patient have a diagnosis of alpha-mannosidosis?
☐ Yes ☐ No Will the requested drug be used for the treatment of non-CNS manifestations of alpha-mannosidosis?
☐ Yes ☐ No Was the diagnosis confirmed by a documented deficiency of alpha-mannosidase activity as measured in blood leukocytes or fibroblasts?
→ ☐ Yes ☐ No Was the diagnosis confirmed by genetic testing documenting a mutation in the MAN2B1 gene?

For Continuation Requests (clinical documentation required for all requests):

☐ Yes ☐ No Has the patient demonstrated a response to therapy (e.g., improvement in 3-minute stair climbing test [3MSCT] from baseline, improvement in 6-minute walking test [6MWT] from baseline, improvement in forced vital capacity [FVC, % predicted] from baseline, reduction in serum or urine oligosaccharide concentration from baseline)?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required)*: ______________________________ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.