MEDICARE FORM VPRIV® (velaglucerase alfa) Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

For Medicare Advantage Part B:
Phone: 1-866-503-0857 (TTY:711)
FAX: 1-844-268-7263

For other lines of business:
Please use other form.

Note: Vpriv is non-preferred. The preferred products are Cerezyme and Elelyso.

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:

Address: | City: | State: | ZIP:

Home Phone: | Work Phone: | Cell Phone:

DOB: | Allergies: | Email:

Current Weight: ________ lbs or ________ kgs Height: ________ inches or ________ cms

B. INSURANCE INFORMATION

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)*: ☐ **Hematologist** ☐ **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: ______________
City: ______________ State: ______ ZIP: ______
Phone: ______________ Fax: ______________
TIN: ______________ PIN: ______________
NPI: ______________

Dispensing Provider/Pharmacy: *(Patient selected choice)*

☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: ______________
Name: ______________
Address: ______________
City: ______________ State: ______ ZIP: ______
Phone: ______________ Fax: ______________
TIN: ______________ PIN: ______________
NPI: ______________

E. PRODUCT INFORMATION

Request is for: VPRIV (velaglucerase alfa) Dose: ________ **Directions for Use:** ______________
HCPCS Code: ______________

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

Primary ICD Code: ______________ ☐ Other ICD Code: ______________

G. CLINICAL INFORMATION - Required clinical information must be completed for ALL precertification requests.

For Initial Requests:

Note: Vpriv is non-preferred. The preferred products are Cerezyme and Elelyso.

☐ Yes ☐ No Has the patient had prior therapy with the requested product within the last 365 days?

☐ Yes ☐ No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply)

☐ Cerezyme (imiglucerase) ☐ Elelyso (taliglucerase alfa)

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis? (select all that apply)

☐ Cerezyme (imiglucerase) ☐ Elelyso (taliglucerase alfa)

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Continued on next page

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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 All Requests (clinical documentation required for all requests):

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

→ ☐ Yes ☐ No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (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 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 the 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 member's ability to tolerate a large volume or load or predispose the member 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:
☐ Cardiopulmonary: ________________
☐ Respiratory: ________________
☐ Renal: ________________
☐ Other: ________________

Please indicate which type of Gaucher disease the patient has been diagnosed with: ☐ Type 1 ☐ Type 2 ☐ Type 3 ☐ Other

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

☐ Yes ☐ No Was the diagnosis of Gaucher disease confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase (glucosidase) enzyme activity or by genetic testing?

☐ Yes ☐ No Has the patient had an ineffective response, contraindication, or intolerance to Elelyso?

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

☐ Yes ☐ No Is the patient experiencing an inadequate response or any intolerable adverse events from therapy with VPRIV?

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.