

## Specialty Medication Review Program

## **Inborn Errors of Metabolism (IEM)** (Health Professional Administration)

Medical Benefit Complete this form and fax to: If you are not buying and billing this medication, indicate which specialty pharmacy will be used (Pharmacy will be used (except where noted below for Limited Distribution Drugs): **Medical Specialty Unit** ☐ Accredo Health ☐ Walgreens Specialty Pharmacy Fax #: 1-800-306-0188 **Fax:** 1-888-773-7386 Fax: 1-866-435-2173 Phone #: 1-800-499-1275 Phone: 1-866-413-4137 Phone: 1-866-435-2171 Complete ALL the following Patient/Prescriber Information: (Please Print) **Patient Information** Patient Name: Patient Phone #: ( Patient ID #: Patient Birthdate: List Patient Allergy (If Any) **Prescriber Information** Prescriber Specialty: Prescriber Name: Prescriber Address: Prescriber Phone #: Prescriber Fax #: Prescriber NPI #: Office Contact: Extension: Location of Infusion: □ Prescriber office ☐ Home/Homecare agency: ☐ Other: \_ □ Outpatient facility **Servicing Prescriber NPI** (if different from the ordering prescriber): Provide address of infusion location above for medication shipping: Complete the following for the product being requested: Medical Benefit ☐ Elaprase (J1743) ☐ Amvuttra (J0225) □ Brineura (J0567) ☐ Cerezyme (J1786) ☐ Crysvita (J0584) ☐ Elelyso (J3060) Orsini Hospital Only 1-800-410-8575 **US Bioservices** 1-866-526-4984 ☐ Fabrazyme (J0180) ☐ Kanuma (J2840) ☐ Lamzede (J0217) ☐ Lenmeldy ☐ Elfabrio (J2508) ☐ Givlaari (J0223) ☐ Lumizyme (J0221) ☐ Mepsevii (J3397) ☐ Naglazyme (J1458) ☐ Nexviazyme (J0219) ☐ Nulibry ☐ Onpattro Non-Facility - (J3490) Accredo Only Facility - (J0222) Orsini 1-800-410-8575 **US Bioservices** 1-866-526-4984 ☐ Oxlumo (J0224) ☐ Pombiliti (J1203) ☐ Rivfloza ☐ Vimizim (J1322) □ VPRIV (J3385) ☐ Xenpozyme (J0218) Orsini Cardinal 1-800-410-8575 1-888-662-6779 **Medication/Medical and Dispensing Information** Height Dose Weight (lbs./kg) & Date Procedure Code Frequency 1. Diagnosis/ICD-10: (\*Attach ALL test results confirming diagnosis) 2. Indicate if this is a: NEW START on medication **RECERTIFICATION** of prior authorization previously **approved by THIS PLAN**. **CONTINUATION** of therapy previously **approved by a DIFFERENT** insurance plan or obtained via clinical trial. (Date medication started: **Questions/Indications for Medical Necessity** \*\* See the Inborn Errors of Metabolism Policy (Pharmacy-23) for full Prior Authorization criteria \*\* 1. Provide patient symptoms: \_ 2. Include ALL previous medications used to treat this diagnosis with dates & outcomes: **Drug Name** Dose Frequency Period of use Outcome Start: End: Start: End: 3. Attach recent progress notes with ALL requests:

ATTACH CLINICAL NOTES RELATED TO THIS REQUEST. IF DOCUMENTATION IS NOT PROVIDED, IT MAY DELAY THE REQUEST.

Date:

\*Prescriber Signature: I certify the above is true and accurate to the best of my knowledge.

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