Nexviazyme

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical*	❑ *Home*	❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital*	❑ *Office*	❑ *Pharmacy*

What is the ICD-10 code? _____

Site of Service Questions:

A. Where will this drug be administered?

❑ Ambulatory surgical, *skip to Clinical Questions*	❑ Home infusion, *skip to Clinical Questions*
❑ Off-campus Outpatient Hospital	❑ On-campus Outpatient Hospital
❑ Physician office, *skip to Clinical Questions*	❑ Pharmacy, *skip to Clinical Questions*

B. Is this request to continue previously established treatment with the requested medication?
❑ Yes, this is a continuation of an existing treatment
❑ No, this is a new therapy request (patient has not received requested medication in the last 6 months), *skip to Clinical Criteria Questions*

C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of infusion

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rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

D. Does the patient have laboratory confirmed anti-avalglucosidase alfa-ngpt antibodies? ***ACTION REQUIRED: If yes, please attach supporting clinical documentation.*** ❑ *Yes, skip to Clinical Criteria Questions* ❑ No

E. 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? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Does the patient have severe venous access issues that require the use of a special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. 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? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.*** ❑ Yes ❑ No

Criteria Questions:

1. What is the diagnosis?

❒ Late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency) (*If checked, go to 2*)

❒ Other, please specify. _____ (*If checked, go to 2*)

2. Is the request for continuation of therapy with the requested medication?
❒ Yes, *Continue to 3*
❒ No, *Continue to 4*

3. Is the patient responding to therapy (e.g., improvement, stabilization, or slowing of disease progression for motor function, walking capacity, respiratory function, or muscle strength)? ***ACTION REQUIRED***: If yes, supporting chart notes documenting a positive response to therapy (e.g., improvement, stabilization, or slowing of disease progression for motor function, walking capacity, respiratory function, muscle strength) are required.
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

4. What is the patient's age?

❒ Less than 1 year (*If checked, go to 5*)

❒ 1 year of age or older (*If checked, go to 5*)

5. Was the diagnosis confirmed by enzyme assay demonstrating a deficiency of acid alpha-glucosidase (GAA) enzyme activity OR by genetic testing? ***ACTION REQUIRED***: If yes, attach acid alpha-glucosidase enzyme assay or genetic testing results supporting diagnosis.
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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