aetna®

Enzyme Replacement Treatment Medication Precertification Request

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

Aetna Precertification Notification
503 Sunport Lane Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

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:	E-mail:	

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

B. INSURANCE INFORMATION

Aetna Member ID #: _____ Does patient have other coverage? ☐ Yes ☐ No
Group #: _____ If yes, provide ID#: _____ Carrier Name: _____
Insured: _____ 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 E-mail:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Metabolic Specialist** ☐ **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)*
☐ *Outpatient Infusion Center* ☐ Physician's Office
☐ Specialty Pharmacy ☐ Mail Order
☐ Retail Pharmacy ☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. OUTPATIENT INFUSION TREATMENT

Requesting Outpatient Infusion Treatment? ☐ Yes ☐ No *If Yes,* ***CPT Code:*** ☐ *S9357* ☐ *96305* ☐ *96366* ☐ *Other* _____

F. PRODUCT INFORMATION

Request is for: ☐ Aldurazyme ☐ Brineura ☐ Cerezyme ☐ Elaprase ☐ Elelyso ☐ Fabrazyme
☐ Kanuma ☐ Lumizyme ☐ Myozyme ☐ Naglazyme ☐ Vimizim ☐ VPRIV

Dose/Frequency: _____

G. DIAGNOSIS INFORMATION – Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code : _____ **Secondary ICD Code :** _____ **Other ICD Code:** _____

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

For Aldurazyme:
☐ Yes ☐ No Is the patient diagnosed with Hurler and Hurler-Scheie forms of mucopolysaccharidosis I (MPS I)?
☐ Yes ☐ No Does the patient have the Scheie form of MPS I?
→ ☐ Yes ☐ No Does the patient have moderate to severe symptoms?

For Elaprase:
☐ Yes ☐ No Does the patient have a documented diagnosed with Hunter syndrome (mucopolysaccharidosis II)?

For Fabrazyme:
☐ Yes ☐ No Is the patient diagnosed with Fabry disease?

For Kanuma:
☐ Yes ☐ No Does the patient have clinical evidence of lysosomal acid lipase (LAL) enzyme activity deficiency?
→ ☐ Yes ☐ No Has LAL been confirmed by dried blood spot (DBS) testing?
→ Please provide the date of the DBS testing: ____/____/____
What is the patient's ALT measurement and date obtained: _____ U/L Date: ____/____/____
The patient's ALT is (based on age and gender-specific normal ranges): ☐ ≥ 1.5 times the upper limit of normal
☐ < 1.5 times the upper limit of normal
☐ Yes ☐ No ☐ N/A Was the elevation in ALT confirmed by a repeat test obtained at least 1 week apart?
→ Please indicate the measurement and date the second ALT was drawn: _____ U/L Date: ____/____/____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

H. CLINICAL INFORMATION *(Continued)*

For Cerezyme, Elelyso, VPRIV:

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

☐ Yes ☐ No Does the patient have neurologic findings consistent with Type 3 Gaucher disease?
→ Please indicate the findings: ☐ Encephalopathy ☐ Cerebellar ataxia ☐ Opthalmoplegia ☐ Spasticity ☐ Progressive myoclonic epilepsy ☐ Dementia ☐ Other:_____

☐ Yes ☐ No Does the patient have moderate to severe anemia (Hgb ≤ 11.5g/dl for females or 12.5g/dl for males)?

☐ Yes ☐ No Does the patient have significant hepatomegaly (liver size 1.25 or more times normal –1750cc in adults)?

☐ Yes ☐ No Does the patient have significant splenomegaly (spleen size 5 or more times normal – 875cc in adults)?

☐ Yes ☐ No Does the patient have skeletal disease beyond mild osteopenia and Erlenmeyer flask deformity?

☐ Yes ☐ No Does the patient have symptomatic disease, including abdominal or bone pain, fatigue, exertional limitation, weakness or cachexia?

☐ Yes ☐ No Does the patient have thrombocytopenia (platelet count ≤ to 120,000/mm^3)?

For Lumizyme:

☐ Yes ☐ No Is the patient diagnosed with Pompe disease?

For Myozyme:

☐ Yes ☐ No Is the patient diagnosed with infantile-onset Pompe disease?

For Naglazyme:

☐ Yes ☐ No Is the patient diagnosed with mucopolysaccharidosis VI (MPS VI)?

For Vimizim:

☐ Yes ☐ No Is the patient diagnosed with mucopolysaccharidosis type IVA (MPS IVA; Morquio A syndrome)?

☐ Yes ☐ No Does the patient have clinical signs and symptoms of MPS IVA?
→ Please indicate if there is documentation of any of the following:
- ☐ Documented reduced fibroblast
- ☐ Leukocyte N- acetylgalactosamine-6 sulfatase (GALNS) enzyme activity
- ☐ Genetic testing confirming the diagnosis of MPS IVA
- ☐ None of the above

For Continuation Requests for All Drugs Above:

What type of clinical response has the patient experienced on therapy?
Please indicate response: ☐ No response ☐ Minimal response ☐ Adequate response ☐ Significant improvement

For Brineura:

☐ Yes ☐ No Is the patient diagnosed with Jansky-Bielschowsky disease also known as symptomatic late infantile neuronal ceroid lipofuscinosis type 2 (CLN2), and tripeptidyl peptidase 1 (TPP1) deficiency?

☐ Yes ☐ No Has the patient undergone diagnostic testing?
→ How was the diagnosis of CLN2 confirmed? (Please select appropriate tests):
☐ Detection of pathogenic mutations in each allele of the TPP1 gene (also known as the CLN2 gene)
☐ TPP1 deficiency ☐ Other- please explain: _____
Please provide test date: ____/____/____

☐ Yes ☐ No Does the patient have an acute intraventricular access device related complication?
→ Which of the following intraventricular access device complications has occurred?
☐ Device Failure ☐ Device-related infection ☐ Leakage ☐ Other- please explain: _____

☐ Yes ☐ No Does the patient have a ventriculoperitoneal shunt?

For Continuation Requests (Brineura):

☐ Yes ☐ No Is there documentation indicating that the use of Brineura has slowed the loss of ambulation from baseline?

I. 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.