

GALAFOLD

PRIOR AUTHORIZATION REQUEST

PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

Today’s Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today’s Date): _____

| | | | |
|-----------------------|-------------------|--------------------|-------------------|
| Patient Name (First): | Last: | M: | DOB (mm/dd/yyyy): |
| Patient Address: | City, State, Zip: | Patient Telephone: | |
| Member ID Number: | Group Number: | | |

PRESCRIBER/CLINIC INFORMATION

| | | | |
|-------------------|------------------|---------------|---------------|
| Prescriber Name: | Prescriber NPI#: | Specialty: | Contact Name: |
| Clinic Name: | Clinic Address: | | |
| City, State, Zip: | Phone #: | Secure Fax #: | |

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

| | |
|---|---------------------|
| Please select the patient’s diagnosis: <input type="checkbox"/> Fabry disease <input type="checkbox"/> Other (ICD code, plus description): _____ | |
| Medication Requested: | Strength: |
| Dosing Schedule: | Quantity per Month: |
| For all requests: | |
| 1. Is the patient currently treated with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 2. Is the prescriber a specialist in the area of the patient’s diagnosis (e.g., endocrinologist, geneticist, nephrologist), or has the prescriber consulted with a specialist in the area of the patient’s diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 3. Does the patient have any FDA labeled contraindications to the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify FDA labeled contraindications: _____ | |
| 4. Will the patient be using the requested agent in combination with enzyme replacement therapy (ERT) (e.g., Elfabrio, Fabrazyme) for the requested indication? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 5. Can the requested quantity (dose) be achieved with a lower quantity of a higher strength? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain: _____ | |
| 6. Was the diagnosis confirmed by mutation in the galactosidase alpha (GLA) gene? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 7. Is the patient’s age within FDA labeling for the requested indication for the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please give rationale in support of using the requested agent for the patient’s age for the requested indication: _____ | |
| 8. Does the patient have a confirmed amenable GLA variant based on in vitro assay data? Note: A complete list of amenable variants is available in the Galafold prescribing information, or a specific variant can be verified as amenable at http://www.galafoldamenabilitytable.com/hcp <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify: _____ | |
| For renewal requests: | |
| 9. Has the patient had clinical benefit with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Please fax or mail this form to:
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Clinical Review Department
2900 Ames Crossing Road Suite 200
Eagan, MN 55121

TOLL FREE

Phone:

Fax: 877.243.6930

BCBSIL: 800.285.9426

BCBSMT: 888.723.7443

BCBSNM: 800.544.1378

BCBSOK: 800.991.5643

BCBSTX: 800.289.1525

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