Lumizyme® (alglucosidase alfa) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Phone: 1-866-503-0857
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

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):* ☐ **Neurologist** ☐ **Cardiologist** ☐ **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)*

☐ Physician's Office ☐ Retail Pharmacy

☐ Specialty Pharmacy ☐ Other: _____

Name: _____

Address: _____

Phone: _____ FAX: _____

TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: Lumizyme (alglucosidase alfa) Dose: _____ **Directions for Use:** _____

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 All Requests (clinical documentation required for all requests):

☐ Yes ☐ No Is this infusion request in an outpatient 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 laboratory confirmed alglucosidase alfa antibodies?

☐ 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: _____

☐ Yes ☐ No Is the patient diagnosed with Pompe disease (acid alpha-glucosidase [GAA] deficiency)?

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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 Initiation Requests (clinical documentation required for all requests):

☐ Yes ☐ No Was the diagnosis of Pompe disease confirmed by enzyme assay demonstrating a deficiency of acid alpha-glucosidase (GAA) enzyme activity OR by genetic testing?

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

☐ Yes ☐ No Is the patient responding to therapy (e.g., improvement, stabilization, or slowing of disease progression for motor function, walking capacity, cardiorespiratory function, decrease in left ventricular mass index (LVMI), delay in death)?

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.