Nexviazyme® (avalglucosidase alfa-ngpt) 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: Nexviazyme (avalglucosidase alfa-ngpt) 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 avalglucosidase 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 late-onset Pompe disease (lysosomal 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 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, respiratory function, or muscle strength)?

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.