pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

ENZYME REPLACEMENTS, GAUCHER DISEASE PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Enzyme Replacements, Gaucher Disease** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.

Drug requested:	Strength:	
Dose/directions:	Quantity:	Refills:
Diagnoses *(submit documentation)*:	Dx codes (*required*):	
INITIAL requests		
Does the beneficiary have a diagnosis of Gaucher disease supported by one of the following? *Check all that apply.* ☐enzyme assay demonstrating a deficiency of beta-glucocerebrosidase (glucosidase) activity ☐DNA testing confirming the diagnosis	☐Yes ☐No	*Submit documentation.*
Does the beneficiary have any of the following? *Check all that apply.* ☐anemia ☐hepatomegaly ☐splenomegaly ☐bone disease ☐interstitial lung disease ☐thrombocytopenia	☐Yes ☐No	*Submit documentation.*
***For Cerdelga*:** What is the beneficiary's CYP2D6 metabolizer status? *Check ONE.* ☐poor metabolizer (PM) ☐extensive metabolizer (EM) ☐intermediate metabolizer (IM) ☐ultra-rapid metabolizer		*Submit documentation.*
***For a non-preferred medication*:** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agents? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.*	☐Yes ☐No	*Submit documentation.*
RENEWAL requests		
Did the beneficiary experience improvement in disease severity since initiating treatment with the requested medication?	☐Yes ☐No	*Submit documentation.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: