

Ticket #: _____ Request Date: _____ Request Time: _____

Cerdelga® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information (required)	
Select the diagnosis below:	
<input type="checkbox"/> Type 1 Gaucher disease	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	

Clinical Information:
Is the patient an extensive metabolizer (EM), intermediate metabolizer (IM), or poor metabolizer (PM) of cytochrome P450 enzyme (CYP) 2D6 as detected by an FDA-cleared test? <input type="checkbox"/> Yes <input type="checkbox"/> No

Reauthorization:
If this is a reauthorization request, answer the following question:
Select if the following applies to confirm the patient's condition has not progressed:
<input type="checkbox"/> Hemoglobin level decreased greater than 1.5 g/dL from baseline
<input type="checkbox"/> Platelet count decreased greater than 25% from baseline
<input type="checkbox"/> Spleen volume increased greater than 25% from baseline
<input type="checkbox"/> Liver volume increased greater than 20% from baseline

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Authorized Medical Signature:	
Telephone:	Date:

Please note that this form is to be completed by the prescribing physician. This document and others, if attached, contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. If you are not the intended recipient, please notify the sender immediately.
 Office use only: Cerdelga_Comm_2017Feb

Cerdelga[®] Prior Authorization Request Form (Page 2 of 2)
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When Completed Return To:

ProCare PBM Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

Please note: This request may be denied unless all required information is received.