GHP Family Pharmacy Customer Service
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GeisingerHealthPlan.com

ENZYME REPLACEMENTS, GAUCHER DISEASE PRIOR AUTHORIZATION FORM *(Form Effective 1/1/20)*

Prior authorization guidelines for Enzyme Replacements, Gaucher Disease and Quantity Limits/Daily Dose Limits are available on Geisinger Health Plan's website at https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger

☐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 submit to PromptPA https://ghp.promptpa.com OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation

Prescriber Signature:	Date: