



Please complete ALL information below and fax your request to 1-888-671-5285

Galafold® Coverage Determination Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required) Provider Information (required)

| | | | | | |
|-----------------|--------|------|------------------------|-----------------|------|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NPI#: | Specialty: | |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | Office Contact: | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |

Medication Information (required)

| | | |
|--|-----------|--------------|
| Medication Name: Select one of the following: <input type="checkbox"/> Request is for GENERIC <input type="checkbox"/> Request is for BRAND (unable to take the generic) <input type="checkbox"/> Check if request is for continuation of therapy | Strength: | Dosage Form: |
| Directions for Use: | | |

Clinical Information (required)

Select the Type(s) of Coverage Determination Requested:

Prior Authorization- Request is for a drug that requires prior authorization under the plan.

Quantity Limit- Request is for an exception to the plan's quantity limit.
Quantity per DAY requested? _____

Select the diagnosis below:

Fabry disease

Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is there documentation the patient has an amenable galactosidase alpha gene (GLA) variant per FDA labeling information? Yes No

Is Galafold prescribed by or in consultation with a clinical genetics specialist? Yes No

Reauthorization:

If this is a reauthorization request, answer the following questions:

Is there documentation the patient has had a positive response to therapy? Yes No

Is Galafold prescribed by or in consultation with a clinical genetics specialist? Yes No

Quantity Limit Requests:

Is there a high risk of significant adverse clinical outcome with medication change or dosage change? Yes No

Is the requested quantity and dose within FDA approved maximum dosing limits or supported by peer-reviewed medical literature, accepted standards of medical practice and/or medical compendia? Yes No

If **yes**, please specify: _____

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

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

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