Prescriber Criteria Form

Cerdelga 2025 PA Fax 1188-A v1 010125.docx
Cerdelga (eliglustat)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Cerdelga (eliglustat).

Drug Name:
Cerdelga (eliglustat)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of type 1 Gaucher disease (GD1)? [If no, then no further questions.]	Yes ◯	No ◯
2	Was the diagnosis of Gaucher disease confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing? [If no, then no further questions.]	Yes ◯	No ◯
3	Has the patient's CYP2D6 metabolizer status been established using a Food and Drug Administration (FDA)-cleared test? [If no, then no further questions.]	Yes ◯	No ◯
4	Is the patient a CYP2D6 extensive metabolizer (EM)? [If yes, then no further questions.]	Yes ◯	No ◯
5	Is the patient a CYP2D6 intermediate metabolizer (IM)? [If yes, then no further questions.]	Yes ◯	No ◯
6	Is the patient a CYP2D6 poor metabolizer (PM)?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____