



**Aldurazyme® (Iaronidase)**

PRIOR AUTHORIZATION REQUEST FORM

For authorization, **please answer each question, include patient chart notes to document clinical information, and fax this form back to the PEHP Prior Authorization Department at (801) 245-7774** or mail to: PEHP Pharmacy services, 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization questions, you may phone the PEHP Customer Service at (801) 366-7551.

1. Date:	2. Patient Name:	3. ID #:
4. D.O.B:	5. Physician:	6. Office Phone:
7. Office Fax:	8. Office Contact:	9. Dose Request:
10. Sex:	11. Weight:	

Authorization is requested from: \_\_\_\_\_ to \_\_\_\_\_

Question	Yes	No	Comments/Notes
12. Please select the diagnosis of the patient: <input type="checkbox"/> Hurler Syndrome (MPS IH) <input type="checkbox"/> Hurler-Scheie syndrome (MPS IH-S) <input type="checkbox"/> Scheie form (MPS IS) <input type="checkbox"/> Other*(Please List): _____			*Please include clinical studies or articles to support the use of Aldurazyme® if you listed a non-FDA approved indication
13. Has the diagnosis been confirmed by diagnostic method (measurement of alpha-iduronidase activity) or antenatal diagnosis (enzymatic assay)?			
14. Please select the severity of the patient's symptoms: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe			
15. If the diagnosis is Scheie form, please list at least two moderate-to-severe symptoms that the patient is experiencing: 1. _____ 2. _____ 3. _____			
16. Has the patient received 26 weeks of previous Aldurazyme® therapy and additional therapy is being requested?			
17. If 'yes' to 16, has the patient experienced an improvement in lung function (forced vital capacity [FVC]) from when therapy was started?			Documentation is required.
18. Source of Medication (please select one): <input type="checkbox"/> Accredo <input type="checkbox"/> Approved Home Health			If no selection is made, Accredo <u>must</u> be used.
19. Indicate the facility Aldurazyme® is to be infused: _____			
20. Physician's Signature: _____			

PEHP USE ONLY	
<b>Site of approval:</b> Accredo or Approved Home Health	<b>Home Health J-code:</b> J1931

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