Aldurazyme® (laronidase)

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: ☐ Hurler Syndrome (MPS IH) ☐ Hurler-Scheie syndrome (MPS IH-S) ☐ Scheie form (MPS IS) ☐ 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: ☐ Mild ☐ Moderate ☐ 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): ☐ Accredo ☐ Approved Home Health			If no selection is made, Accredo must be used.
19. Indicate the facility Aldurazyme® is to be infused:			
20. Physician's Signature: _____			

PEHP USE ONLY	
Site of approval: Accredo or Approved Home Health	**Home Health J-code**: J1931