



**Aldurazyme
(Laronidase)**

**Prior Authorization Form
Curascript
Fax (888) 773-7386**

| | | | |
|---|---------------|--|----------------|
| Last Name | First Name | Prescriber's Name | Specialty |
| Home Phone | Work Phone | Office Phone | Office Fax |
| Home Address | City | State | ZIP |
| Address | City | State | ZIP |
| SCAN ID number | Date of Birth | Est. Start Date | Office Contact |
| For Specialty Medications Only: Shipping Address (if different from home address) <input type="checkbox"/> Physician <input type="checkbox"/> Home | | Special Instructions (i.e. Non-English Speaking Patient, etc.) | |

| | |
|-------------|-------------|
| Medication: | Diagnosis: |
| Sig: | Qty: |
| Refills: | ICD 9 Code: |

| | | | | |
|---|-------|-----------------|-----------|--------------|
| Secondary/ Supplemental Insurance Company | Phone | Name of Insured | ID Number | Group Number |
|---|-------|-----------------|-----------|--------------|

1. Is the diagnosis or indication for the treatment of Mucopolysaccharidosis I: Hurler, Hurler-Scheie forms or Scheie form with moderate to severe symptoms?
2. Has the diagnosis been confirmed by laboratory or genetic testing?
3. Is Aldurazyme being administered through one of the following: the Home Health, physician's office or outpatient services?
4. Is Aldurazyme being administered by the patient or a caregiver at home?
5. Are there any other comments, diagnoses, symptoms, and/or any other information the caller feels is important to this review?

Physician's Signature: _____ NPI/DEA #: _____ Date: _____

For Internal Use Only
 Approved Denied Reviewer's Initials _____ Decision Date _____
 Comments _____

Notice: **Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.** Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at <http://www.scanhealthplan.com>.