



Aldurazyme
(Laronidase)
Prior Authorization Form

Express Scripts
Phone 800-417-8164
Fax 877-837-5922

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
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- 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 the medication supplied by Retail, Home Infusion, Long Term Care or other pharmacies?**
- 4. Is the medication supplied and administered by a Physician's office?**
- 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	
<input type="checkbox"/> Approved <input type="checkbox"/> Denied	Reviewer's Initials _____ Decision Date _____
Comments _____	