Enzyme Replacement Medication Request

Aetna Specialty Pharmacy®
503 Sunport Lane
Orlando, FL 32809

Customer Service: 1-866-782-ASRX (1-866-782-2779) **Fax Order Submission: 1-866-FAX-ASRX (1-866-329-2779)**

For your convenience, this medication request may be submitted via E-PRESCRIBE to Aetna Specialty Pharmacy

Aetna Specialty Pharmacy will verify benefits and contact members to confirm delivery before medication is shipped.

Today's Date: **Date Needed:**

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
Weight:	Height:	Allergies:	

B. INSURANCE INFORMATION

Carrier Name: ____________________
Member ID #: ____________________
Group #: ____________________
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, Carrier Name: ____________________
Member ID#: ____________________
Insured:

Medicare: ☐ Yes ☐ No If yes, ID #: **Medicaid**: ☐ Yes ☐ No If yes, ID #:

C. PHYSICIAN INFORMATION

First Name:		Last Name:	*(Check one):* ☐M.D. ☐D.O. ☐N.P. ☐P.A.	
Address:		City:	State:	ZIP:
Phone:	Fax:	DEA #:	NPI #:	Office Contact:

D. DIAGNOSIS

Primary ICD Code: Other ICD Code:

E. PRESCRIPTION

Please refer to the insurance carrier's participating provider precertification list to verify precertification requirements.

Medication	Directions	Quantity	Refills
☐ **ALDURAZYME** NS IV Bag: ☐100ml ☐250ml ☐ NS Flush Albumin ☐**5%** _____ml/infusion ☐**25%** _____ml/infusion	***DOSE:*** _____mg ***OR*** _____mg/kg (Wt: _____kg ***OR*** _____lbs) ☐ Infuse IV every week over _____ hour(s) ☐ Other:	☐ 1 month ☐ Other:	
☐ **CERDELGA 84MG CAPSULES**	***DOSE:*** 84mg by mouth ____________________	☐ 1 month ☐ Other:	
☐ **CEREZYME** ☐ SWFI ☐ NS Flush NS IV Bag: ☐50ml ☐100ml	***DOSE:*** _____Units ***OR*** _____U/kg (Wt: _____kg ***OR*** _____lbs) ☐ Infuse IV every 2 weeks over _____ hour(s) ☐ Other:	☐ 1 month ☐ Other:	
☐ **ELAPRASE** ☐ NS Flush ☐ 100ml NS IV Bag	***DOSE:*** _____mg ***OR*** _____mg/kg (Wt: _____kg ***OR*** _____lbs) ☐ Infuse IV every week over _____ hour(s) ☐ Other:	☐ 1 month ☐ Other:	
☐ **FABRAZYME** ☐ SWFI ☐ NS Flush NS IV Bag: ☐50ml ☐100ml ☐250ml ☐500ml	***DOSE:*** _____mg ***OR*** _____mg/kg (Wt: _____kg ***OR*** _____lbs) ☐ Infuse IV every 2 weeks over _____ hour(s) ☐ Other:	☐ 1 month ☐ Other:	
☐ **LUMIZYME** ☐ SWFI ☐ NS Flush NS IV Bag: ☐50ml ☐100ml ☐250ml ☐500ml ☐1L	***DOSE:*** _____mg ***OR*** _____mg/kg (Wt: _____kg ***OR*** _____lbs) ☐ Infuse IV every 2 weeks over _____ hour(s) ☐ Other:	☐ 1 month ☐ Other:	
☐ **MYOZYME** ☐ SWFI ☐ NS Flush NS IV Bag: ☐50ml ☐100ml ☐250ml ☐500ml ☐1L	***DOSE:*** _____mg ***OR*** _____mg/kg (Wt: _____kg ***OR*** _____lbs) ☐ Infuse IV every 2 weeks over _____ hour(s) ☐ Other:	☐ 1 month ☐ Other:	
☐ **NAGLAZYME** ☐ NS Flush NS IV Bag: ☐100ml ☐250ml	***DOSE:*** _____mg ***OR*** _____mg/kg (Wt: _____kg ***OR*** _____lbs) ☐ Infuse IV every week over _____ hour(s) ☐ Other:	☐ 1 month ☐ Other:	
☐ **VPRIV** ☐ SWFI ☐ NS Flush ☐100ml NS IV Bag	***DOSE:*** _____Units ***OR*** _____U/kg (Wt: _____kg ***OR*** _____lbs) ☐ Infuse IV every 2 weeks over _____ hour(s) ☐ Other:	☐ 1 month ☐ Other:	
☐ Other:	***DOSE:***		

Pre-Meds: ☐ Solu-Cortef IV: _____mg ☐ Solu-Medrol IV: _____mg ☐ Benadryl IV: _____mg ☐ Other:

Allergy/Anaphylaxis Meds: ☐ Benadryl 25-50mg IVP #_____doses ☐ Epinephrine (1:1000) #_____ampules ☐ Epipen 0.3mg ☐ Epipen Jr 0.15mg

Additional Meds: ☐ Heparin 100U/ml Flush (For Central/PICC Lines) ☐ Emla Cream ☐ Other:

Ship to: ☐ Physician's Office ☐ Patient ☐ Other address:

*Interchange is mandated unless practitioner handwrites the words **"MEDICALLY NECESSARY"** for each medication.*

Prescriber's Signature **(Required by Law):**

Aetna Specialty Pharmacy refers to Aetna Specialty Pharmacy, LLC, a subsidiary of Aetna Inc., which is a licensed pharmacy that operates through specialty pharmacy prescription fulfillment. This pharmacy is a for-profit entity.