



**Enzyme Replacement Treatment
Medication Precertification Request**
Page 1 of 2 (Please complete & return only page 1 if
Aetna Specialty Pharmacy is NOT the dispensing provider.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

Please indicate: Start of treatment Continuation of therapy Today's date: _____ Date needed: _____

Ship to: Doctor's office Patient Other: _____ Phone: _____

Dispensing Provider: Aetna Specialty Pharmacy® or Other: _____
Phone: _____ Fax: _____ TIN: _____ PIN: _____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:		Last Name:	
Address:		City:	State: ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	
Patient Current Weight: _____ lbs or _____ kgs		Patient Height: _____ inches or _____ cms	

B. INSURANCE INFORMATION

Aetna Member ID #: _____	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured: _____	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Circle one): M.D. D.O. N.P. P.A.	
Address:		City:	State:	ZIP:	
Phone:	Fax:	St. Lic. #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	
Specialty (Check one): <input type="checkbox"/> Metabolic Specialist <input type="checkbox"/> Other: _____					

D. DIAGNOSIS INFORMATION

Primary ICD-9: _____
Secondary ICD-9: _____ Other ICD-9 Code: _____

E. CLINICAL INFORMATION

<p><input type="checkbox"/> Yes <input type="checkbox"/> No Does DNA Analysis confirm evidence of genetic mutation?</p> <p>If this Precert request is for Aldurazyme: Which form of MPSI is the patient diagnosed with: <input type="checkbox"/> Hurler form of MPSI <input type="checkbox"/> Hurler-Scheie form of MPSI <input type="checkbox"/> Scheie form of MPSI with moderate to severe symptoms <input type="checkbox"/> Other: _____</p> <p>If this Precert request is for Cerezyme, Ceredase or VPRIV: <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have Type 1 Gaucher disease? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient 18 years or older? <i>If yes, please check all that apply:</i> <input type="checkbox"/> Moderate to severe anemia (Hgb \leq 11.5g/dl for females or 12.5g/dl for males) <input type="checkbox"/> Significant hepatomegaly (liver size 1.25 or more times normal – 1750cc in adults) <input type="checkbox"/> Significant splenomegaly (Spleen size 5 or more times normal – 875cc in adults) <input type="checkbox"/> Skeletal disease beyond mild osteopenia and Erlenmeyer flask deformity <input type="checkbox"/> Symptomatic disease, including abdominal or bone pain, fatigue exertional limitation, weakness or cachexia <input type="checkbox"/> Thrombocytopenia (platelet count \leq to 120,000/mm3)</p>	<p>If this Precert is request for Elaprase: <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient diagnosed with Hunter syndrome MPS II?</p> <p>If this Precert request is for Fabrazyme: <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient diagnosed with Fabry disease?</p> <p>If this Precert request is for Lumizyme: <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient diagnosed with late-onset (non-infantile) Pompe Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient age 8 years or older? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have evidence of cardiac hypertrophy?</p> <p>If this Precert request is for Myozyme: <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have infantile-onset Pompe disease?</p> <p>If this Precert request is for Naglazyme: <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient diagnosed with mucopolysaccharidosis VI?</p> <p>If this Precert request is for Zavesca: <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have mild to moderate Type 1 Gaucher Disease? <i>If yes, please check all that apply for enzyme replacement therapy not being a therapeutic option:</i> <input type="checkbox"/> Allergy <input type="checkbox"/> Hypersensitivity <input type="checkbox"/> Poor venous access <input type="checkbox"/> Other: _____</p>
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Page 2 of 2 (Please complete & return only page 1 if Aetna Specialty Pharmacy is NOT the dispensing provider.)

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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F. PRESCRIPTION INFORMATION – To be completed only if Aetna Specialty Pharmacy is Dispensing Provider (circle selection)

MEDICATION	STRENGTH	DIRECTIONS
Aldurazyme® CPB # 0442	- Recommended Max Dose 0.58mg/kg - Available in 2.9mg/5ml single dose vials - Further dilute with Sodium Chloride 0.9% - Further dilute with 0.1% Albumin (Human)	____ doses with ____ Refills Infuse ____ mg (____ mg/kg) IV over ____ hours every week. Further dilute with: <input type="checkbox"/> Sodium Chloride 0.9% 100ml (for patients weighing 20kg or less) <input type="checkbox"/> Sodium Chloride 0.9% 250ml (for patients weighing greater than 20kg) <input type="checkbox"/> Albumin 5% ____ ml/infusion <input type="checkbox"/> Albumin 25% ____ ml/infusion <input type="checkbox"/> NS Flush: ____ ml Pre ____ ml Post <input type="checkbox"/> Heparin Flush 100U/ml ____ ml Q ____ and PRN (Only for Central/PICC Lines)
Cerezyme® CPB # 0442	- Recommended Max dose 60u/kg - Available in 200U and 400U single dose - Sterile Water for Injection for reconstitution - Further dilute with Sodium Chloride 0.9% - Final volume recommended 100-200ml	____ doses with ____ Refills Infuse ____ U (____ U/kg) IV over ____ hours every ____ weeks. Further dilute with: <input type="checkbox"/> Sodium Chloride 0.9% 50ml <input type="checkbox"/> Sodium Chloride 0.9% 100ml <input type="checkbox"/> NS Flush: ____ ml Pre ____ ml Post <input type="checkbox"/> Heparin Flush 100U/ml ____ ml Q ____ and PRN (Only for Central/PICC Lines)
Fabrazyme® CPB # 0442	- Recommended Max dose 1mg/kg - Available in 5mg and 35mg single dose vials - Sterile Water for Injection for reconstitution - Further dilute with Sodium Chloride 0.9%	____ doses with ____ Refills Infuse ____ mg (____ mg/kg) IV over ____ hours every two weeks. Further dilute with: <input type="checkbox"/> Sodium Chloride 50ml (weight ≤ 35kg) <input type="checkbox"/> Sodium Chloride 100ml (35.1kg-70kg) <input type="checkbox"/> Sodium Chloride 250ml (70.1kg-100kg) <input type="checkbox"/> Sodium Chloride 500ml (> 100kg) <input type="checkbox"/> NS Flush: ____ ml Pre ____ ml Post <input type="checkbox"/> Heparin Flush 100U/ml ____ ml Q ____ and PRN (Only for Central/PICC Lines)
Lumizyme® CPB # 0442	- Recommended Max dose 20mg/kg - Available in 50mg single dose vials - Sterile Water for Injection for reconstitution - Further dilute with Sodium Chloride 0.9%	____ doses with ____ Refills Infuse ____ mg (____ mg/kg) IV over ____ hours every ____ weeks. Further dilute with: <input type="checkbox"/> Sodium Chloride 0.9% 50ml <input type="checkbox"/> Sodium Chloride 0.9% 100ml <input type="checkbox"/> Sodium Chloride 0.9% 250ml <input type="checkbox"/> Sodium Chloride 0.9% 500ml <input type="checkbox"/> Sodium Chloride 0.9% 1000ml <input type="checkbox"/> NS Flush: ____ ml Pre ____ ml Post <input type="checkbox"/> Heparin Flush 100U/ml ____ ml Q ____ and PRN (Only for Central/PICC Lines)
Myozyme® CPB # 0442	- Recommended Max Dose 20mg/kg - Available in 50mg single dose vials - Sterile Water for injection for reconstitution - Further dilute with Sodium Chloride 0.9%	____ doses with ____ Refills Infuse ____ mg (____ mg/kg) IV over ____ hours every two weeks. Further dilute with: <input type="checkbox"/> Sodium Chloride 0.9% 50ml <input type="checkbox"/> Sodium Chloride 0.9% 100ml <input type="checkbox"/> Sodium Chloride 0.9% 250ml <input type="checkbox"/> Sodium Chloride 0.9% 500ml <input type="checkbox"/> Sodium Chloride 0.9% 1000ml <input type="checkbox"/> NS Flush: ____ ml Pre ____ ml Post <input type="checkbox"/> Heparin Flush 100U/ml ____ ml Q ____ and PRN (Only for Central/PICC Lines)
Naglazyme® CPB # 0442	- Round to the nearest whole vial - Recommended Max Dose 1mg/kg - Available in 5mg/5ml single dose vials - Further dilute with Sodium Chloride 0.9%	____ doses with ____ Refills Infuse ____ mg (____ mg/kg) IV over ____ hours every week. Further dilute with: <input type="checkbox"/> Sodium Chloride 0.9% 100ml (for patients weighing ≤ 20kg or susceptible to fluid overload) <input type="checkbox"/> Sodium Chloride 0.9% 250ml (for patients weighing greater than 20kg) <input type="checkbox"/> NS Flush: ____ ml Pre ____ ml Post <input type="checkbox"/> Heparin Flush 100U/ml ____ ml Q ____ and PRN (Only for Central/PICC Lines)
VPRIV® CPB # 0442	- Recommended Max dose 60u/kg - Available in 200U and 400U single dose - Sterile Water for Injection for reconstitution - Further dilute with Sodium Chloride 0.9%	____ doses with ____ Refills Infuse ____ U (____ U/kg) IV over ____ hours every ____ weeks. Further dilute with Sodium Chloride 0.9% to final volume of ____ ml: <input type="checkbox"/> Sodium Chloride 0.9% 100ml <input type="checkbox"/> NS Flush: ____ ml Pre ____ ml Post <input type="checkbox"/> Heparin Flush 100U/ml ____ ml Q ____ and PRN (Only for Central/PICC Lines)
Elaprase® CPB # 0442	- Recommended Max Dose 0.5mg/kg - Available in 6mg (2mg/ml 3ml) single dose vials - Further dilute with 100ml of 0.9% Sodium Chloride	____ doses with ____ Refills Infuse ____ mg (____ mg/kg) IV over ____ hours every ____ weeks. Further dilute with: <input type="checkbox"/> Sodium Chloride 0.9% 100ml <input type="checkbox"/> NS Flush: ____ ml Pre ____ ml Post <input type="checkbox"/> Heparin Flush 100U/ml ____ ml Q ____ and PRN (Only for Central/PICC Lines)

Zavesca®: To order contact Zavesca.com (phone 888-281-5582 / fax 866-413-4139)

<input type="checkbox"/> Dexamethasone ____ mg IVP PRN reaction ____ Refills	<input type="checkbox"/> Epinephrine ____ mcg SQ ____ IVP PRN reaction ____ Refills
<input type="checkbox"/> Diphenhydramine ____ mg IVP PRN reaction ____ Refills	

***If Aetna Specialty Pharmacy is the dispensing pharmacy, patient benefits will be verified before product is shipped.**

***If the prescriber is providing the drug, the provider must verify benefits.**

Prescriber's Signature: _____ Date: ____/____/____

(Required by law if this Precertification Request is also used as an Aetna Specialty Pharmacy prescription order.)

Interchange is mandated unless practitioner writes the words "NO SUBSTITUTION" in this space: _____