



# Aldurazyme® (Iaronidase) Medication Precertification Request

Page 1 of 2

(All fields must be completed and legible for precertification review.)

**Aetna Precertification Notification**

Phone: 1-866-752-7021

FAX: 1-888-267-3277

**For Medicare Advantage Part B:**

Phone: 1-866-503-0857

FAX: 1-844-268-7263

Please indicate:  Start of treatment, start date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Continuation of therapy, date of last treatment: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Precertification Requested By:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

### A. PATIENT INFORMATION

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

### B. INSURANCE INFORMATION

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:		(Check one): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address:			City:	State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider E-mail:		Office Contact Name:		Phone:	
Specialty (Check one): <input type="checkbox"/> Ophthalmologist <input type="checkbox"/> Other: _____					

### D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

<b>Place of Administration:</b> <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____		<b>Dispensing Provider/Pharmacy: (Patient selected choice)</b> <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other: _____ Name: _____ Address: _____ Phone: _____ FAX: _____ TIN: _____ PIN: _____	
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### E. PRODUCT INFORMATION

**Request is for: Aldurazyme (Iaronidase) Dose:** \_\_\_\_\_ **Directions for Use:** \_\_\_\_\_

### F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other any other where applicable (\*).

**Primary ICD Code:** \_\_\_\_\_  **Other ICD Code:** \_\_\_\_\_

### G. CLINICAL INFORMATION - Required clinical information must be completed for ALL precertification requests.

**For All Requests (clinical documentation required for all requests):**

Yes  No Is this infusion request in an outpatient hospital setting?

Yes  No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g. acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?

Yes  No Does the patient have laboratory confirmed Iaronidase IgE antibodies?

Yes  No Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?

Yes  No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?

Yes  No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?

Yes  No Does the patient have a diagnosis of mucopolysaccharidosis I (MPS I)?

Please provide a description of the behavioral issue or impairment: \_\_\_\_\_

Please provide a description of the condition:  Cardiopulmonary: \_\_\_\_\_  
 Respiratory: \_\_\_\_\_  
 Renal: \_\_\_\_\_  
 Other: \_\_\_\_\_

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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**G. CLINICAL INFORMATION (continued)** – Required clinical information must be completed in its entirety for all precertification requests.

**For Initiation Requests (clinical documentation required for all requests):**

Yes  No Was the diagnosis confirmed by either an enzyme assay demonstrating a deficiency of alpha-L-iduronidase enzyme activity OR by genetic testing?

Please indicate which of the following forms of MPS I the patient has:

Hurler form

Hurler-Scheie form

Scheie form (Scheie syndrome)

Yes  No Does the patient have moderate to severe symptoms (e.g., normal intelligence, less progressive physical problems, corneal clouding, joint stiffness, valvular heart disease)?

Other: \_\_\_\_\_

**For Continuation Requests (clinical documentation required for all requests):**

Yes  No Has the patient experienced a clinically positive response to therapy while receiving the requested medication (e.g., improvement, stabilization, or slowing of disease progression)?

**H. ACKNOWLEDGEMENT**

**Request Completed By (Signature Required):** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.