Member Name: ______________________________ Member ID: _______________ Member DOB: ________________
Drug Name: _____________________________ Strength: _______________ Directions: ___________________________________
Physician Name: __________________________ Physician Phone #: _________________________ Specialty: ______________________
Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

Horizon NJ Health

Idursulfase (Elaprase – Medical Necessity Request

*****Complete page 1 for Initial Requests Only*****

General Questions:

1. What is the member's current weight? ______ lbs or _________ kg Date: ___________________
2. What is the member's current height? ______ inches or _______ cm Date: ___________________

Diagnosis Information (please indicate the diagnosis and answer the related questions):

1. Does the member have a documented diagnosis of Hunter Syndrome (Mucopolysaccharidosis II, MPS II)?
   □ Yes □ No
   - If no, what is the member's diagnosis? ____________________________
2. Has the diagnosis been confirmed by the following?
   □ Deficient iduronate 2-sulfatase (I2S) enzyme activity present in cells (except mature red blood cells) in the presence of normal activity of at least one other sulfatase
   □ Detection of pathogenic mutations in the IDS gene by molecular genetic testing
   □ Other (please specify) ____
3. Does the member have documentation of baseline values for one of the following?
   □ 6 minute walk test (6-MWT)
   □ Percent predicted forced vital capacity (FVC)
   □ Spleen or liver volume for patients under 5 years of age
   □ Other (please specify) ____
4. Is the drug being prescribed by or in consultation with a physician who specializes in the treatment of inherited metabolic disorders? **Yes** or **No**

Physician office's signature*__________________________________ Print Name_________________________________

***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: _______________________________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: ______________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

****Complete page 2 only for Subsequent/Renewal requests****

1. What is the member's diagnosis?
   - □ Hunter Syndrome (Mucopolysaccharidosis II, MPS II)
   - □ Other, please specify ____

2. Is the request for dose change? **Yes** or **No**

   a. If Yes, answer following:
      - o What is the dose requested? ____
      - o What was the previous dose? ____
      - o What is the member's current weight? ______ lbs or _________ kg
      - o What is the member's current height? ______ inches or _______ cm

3. Did the member have beneficial response to therapy as compared to pretreatment baseline values in the same previously used measurement? **Yes** or **No**

   a. If Yes, has the member had any of the following?
      - □ Stabilization or improvement in 6-minute walk test (6-MWT)
      - □ Stabilization or improvement in percent predicted forced vital capacity (FVC)
      - □ Reduction in spleen or liver volume (for patients under 5 years of age)
      - □ Other (please specify) ____

Physician office's signature*________________________________ Print Name________________________________

***Form must be completed and signed by physician or licensed representative from the physician's office**