**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

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

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