

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
ALDURAZYME (laronidase)

Patient name: _____ Medicaid or SS# _____
Physician Name: _____ Contact person: _____
Phone#: _____ Ext.and opt. _____ Fax# _____
Pharmacy _____ Pharmacy Phone#: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY TO (801) 536-0477**

CRITERIA:

- ▶ **DOCUMENTED** and confirmed diagnosis of Hurler and Hurler-Scheie
Confirmed diagnosis is defined as : Hurler and Hurler-Scheie of mucopolysaccharidosis
I (MPS I) and in patients with Scheie form who have severe symptoms.

AUTHORIZATION:

6 months

RE-AUTHORIZATION:

Telephone request from physician's office or pharmacy

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