

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

Patient name: _____ Medicaid ID #: _____
Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____
Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____
Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____
Requested Medication: _____ Strength: _____ Frequency/Day: _____

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 855-828-4992**

CRITERIA:

DOCUMENTED and confirmed diagnosis of Hurler and Hurler-Scheie

NOTES: 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:

Updated letter of medical necessity

9/13/10

<https://medicaid.utah.gov/pharmacy/>