Prescriber Criteria Form

Aldurazyme 2025 PA Fax 573-A v1 010125.docx
Aldurazyme (laronidase)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Aldurazyme (laronidase).

Drug Name:
Aldurazyme (laronidase)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.

1	Does the patient have a diagnosis of mucopolysaccharidosis I (MPS I)? [If no, then no further questions.]	Yes ◯	No ◯
2	Was the diagnosis confirmed by an enzyme assay demonstrating a deficiency of alpha-L-iduronidase enzyme activity and/or by genetic testing? [If no, then no further questions.]	Yes ◯	No ◯
3	Does the patient have Hurler (i.e., severe) or Hurler-Scheie (i.e., intermediate or attenuated) form of Mucopolysaccharidosis I (MPS I)? [If yes, then no further questions.]	Yes ◯	No ◯
4	Does the patient have Scheie (i.e., attenuated) form of Mucopolysaccharidosis I (MPS I) with moderate to severe symptoms?	Yes ◯	No ◯

Comments: _____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ Date:_____