

LYSOSOMAL STORAGE DISORDERS
TELEPHONE 1-800-517-2396 FAX 1-800-588-4297

1. PATIENT INFORMATION *To be completed by the patient*

Last Name		First Name		M.I.
Street Address				
City		State	ZIP	
Day Telephone # (+Area Code)		Night Telephone # (+Area Code)	Mobile Telephone # (+Area Code)	
Date of Birth (MM/DD/YYYY)		Social Security #	Sex (Check One) <input type="checkbox"/> M <input type="checkbox"/> F	
Parent/Guardian Name				

INSURANCE INFORMATION

Primary/Medical Insurance	Secondary/Pharmacy Insurance
Cardholder Name & ID # (If Not Patient)	Cardholder Name & ID # (If Not Patient)
Group/Policy #	Group/Policy #
Insurance Telephone # (+Area Code)	Insurance Telephone # (+Area Code)
Employer	Medicaid #

ALTERNATE SHIPPING ADDRESS

Last Name		First Name		M.I.
Street Address				
City		State	ZIP	

Caremark is committed to protecting the privacy of your health information. We will hold your health information in confidence and will only use and disclose it in accordance with applicable law.

2. PHYSICIAN INFORMATION *To be completed by the physician and staff*

Prescriber's Last Name		Prescriber's First Name	
Hospital/Clinic		Office Contact	
Street Address			
City		State	ZIP
Telephone # (+Area Code)		Fax # (+Area Code)	E-Mail Address
Prescriber's License #		DEA #	NPI #
UPIN#		Medicaid License #	

STATEMENT OF MEDICAL NECESSITY

PRIMARY DIAGNOSIS:

277.5 Mucopolysaccharidosis 1 (MPS 1) 272.7 Fabry Disease
 277.5 Hurler-Scheie Disease (Hurler's Disease) 272.7 Gaucher Disease
 277.5 Mucopolysaccharidosis VI (MPSVI, Maroteaux-Lamy Syndrome)
 Other _____
 Date of Diagnosis: / /

INFUSION TRAINING:

Infusion Training Will Be/Has Been Conducted by the Physician's Office?
 Yes No Date: / /

First Dose of Medication Will Be/Has Been Administered at Physician's Office?
 Yes No Date: / /

Caremark to Refer/Coordinate Infusion Training?
 Yes No

Rx

Patient Weight _____ kg. OR _____ lbs.

Drug Allergies _____

NKDA

Aldurazyme® 2.9 mg Vial With Albumin
 Dose _____ mg/kg Body Weight, IV
 Vol. to Infuse _____ mL Rate _____ mL Frequency _____
 Albumin to Be Added Per Package Insert

Cerezyme® 200/400 Unit Vial
 Dose _____ units/kg Body Weight, IV
 Vol. to Infuse _____ mL Rate _____ mL Frequency _____

Fabrazyme® 5/35 mg Vial
 Dose _____ mg/kg Body Weight, IV
 Vol. to Infuse _____ mL Rate _____ mL Frequency _____

Naglazyme™ 5 mg Vial
 Dose _____ mg/kg Body Weight, IV
 Vol. to Infuse _____ mL Rate _____ mL Frequency _____

Quantity _____ Month(s) Supply

Ancillary Supplies and Kits Provided as Needed for Administration

Refill 12 Months Refill _____ Months
 Dispense As Written Substitution Allowed

Other Prescriber's Notes:

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Prescriber's Signature _____ **Date** _____

3. FAX COMPLETED FORM TOLL-FREE TO CAREMARKCONNECT® @ 1-800-588-4297
Please include copies of the patient's insurance cards (front & back) when faxing the referral to expedite benefit clearance.
Thank you for choosing Caremark!