Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health
Idursulfase (Elaprase) – Medical Necessity Request
****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 members 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**

Physician office's signature*_____ Print Name_____

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

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health
Idursulfase (Elaprase) – Medical Necessity Request
****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:

      - What is the dose requested?
        _____
      - What was the previous dose?
        _____
      - What is the member's current weight? _____ lbs or _____ kg
      - 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 members 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**