

**Health New England**  
**Medication Request Form (MRF) /Prescription Request**

**Cerezyme® (imiglucerase)**

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

**Prior Authorization**

- Prior Authorization Only**
- Prior Authorization and Drug Delivery Request**

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

**Instructions:**

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Cerezyme®. Please complete this form and fax to ICORE Healthcare at (866)-364-2673. If you have any questions regarding this process, please contact ICORE Healthcare at (800) 775-5138.

**Medication Request Information (please complete each section of this form prior to transmittal):**

J-Code = J1785; unit = 1 unit (medication packaged in units)

<b>Patient Information (all required)</b>		<b>Physician Information (all required)</b>	
<b>Patient Name:</b>		<b>Physician Name:</b>	
		<b>Specialty:</b>	
<b>Patient Cell Phone #:</b> (    )    -		<b>NPI#:</b>	
<b>Patient HNE ID#:</b>		<b>HNE Provider #:</b>	
<b>Patient Date of Birth:</b>		<b>DEA #:</b>	
<b>Allergies:</b>		<b>Telephone #:</b> (    )    -	
		<b>Fax #:</b> (    )    -	

<b>Drug Information</b>		
<b>Requested Drug/Strength/Form: Cerezyme®</b>		
<b>Dose, Directions, and length of treatment (please be specific):</b>	<b>Quantity (per month):</b>	<b>Refills:</b>
<b>Physician Signature:</b>	<b>Date:</b>	
<b>Indication:</b>		
<input type="checkbox"/> Type 1 Gaucher Disease <input type="checkbox"/> Type 2 Gaucher Disease <input type="checkbox"/> Type 3 Gaucher Disease		
<b>Documentation of Medical Criteria:</b>		
<input type="checkbox"/> Patient is under the care of a physician specializing in metabolic or genetic disorders. <input type="checkbox"/> Patient has one or more of the following conditions (please check): <ul style="list-style-type: none"> <li><input type="checkbox"/> Anemia</li> <li><input type="checkbox"/> Thrombocytopenia</li> <li><input type="checkbox"/> Bone disease</li> <li><input type="checkbox"/> Hepatomegaly or splenomegaly</li> </ul> <input type="checkbox"/> Request is for continuation of therapy. <input type="checkbox"/> Patient has demonstrated a response to therapy (please explain):		
<b>Other Pertinent History (relative or pertaining to this request):</b>		