Health New England

Medication Request Form (MRF)/Prescription Request
Elaprase ® (idursulfase)

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 Elaprase ® (idursulfase). 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**.

J-Code: C9232 1mg= 1 unit

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

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

Drug Information		
Requested Drug/Strength/Form: ☐ **Elaprase**		
Dose, Directions, and length of treatment (please be specific): **Weight (required)**	**Quantity (per month):**	**Refills:**
Physician Signature:	Date:	

Indication:

- ☐ Hunter syndrome
- ☐ Other (please describe)

Documentation of Medical Necessity (*check all that apply*):

- ☐ Patient is age 5 or older
- ☐ Patient is under the care of a physician specializing in metabolic or genetic disorders.
- ☐ Other pertinent history: ____
- ☐ Request is for continuation of therapy.
  - ☐ Patient has demonstrated a response to therapy (please explain):

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