

Sterling Retiree Rx Prior Authorization Form

CEREZYME

Coverage Criteria / Required Medical Information

Diagnosis confirmed by bone marrow histology, DNA testing or measurement of b-glucocerebrosidase enzyme activity less than 30 percent. Must have at least one of following conditions: anemia, thrombocytopenia, bone disease, hepatomegaly or splenomegaly. Must demonstrate a decrease in liver and spleen volume and/or increase in platelet count and/or increase in Hgb concentration in patients who has previously received 24 months of Cerezyme

Exclusion Criteria:

Concurrent therapy with Zavesca

Member Information

Name					
Enrollment/Card-holder ID Number					
Group/Plan		Male		Female	
Date of Birth		Age		Weight in Kg	
Street Address					
City		State		Zip	

Physician Information

Name					
Agent		Contact Name			
Specialty/Office					
Clinic Name					
Street Address					
City		State		Zip	
Phone		Fax			

Requested Drug

CEREZYME	Reason for Request				
Condition/Diagnosis Related					

Clinical Drug/Lab History Pertinent to Request

Labs: Baseline/Ongoing		Strength/Dosage			
Formulary Alternative(s) Attempted?		Yes:		No:	
Please List Alternative Formulary Drugs					

Comments

Physician Signature: _____

Fax Form to 1-866-481-3704