

## Sterling Retiree Rx Prior Authorization Form

### ELAPRASE (Idursulfase)

**Coverage Criteria / Required Medical Information**

Diagnosis confirmed by either DNA testing or enzymatic analysis.

#### 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

<b>ELEPRASE</b>	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			
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Physician Signature: \_\_\_\_\_

Fax Form to 1-866-481-3704