

## Sterling Retiree Rx Prior Authorization Form

### FABRAZYME (Agalsidase Beta)

**Coverage Criteria / Required Medical Information**

Diagnosis confirmed with an enzyme assay measuring a deficient activity of alpha-galactosidase enzyme or DNA testing.

#### Member Information

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

#### Physician Information

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

#### Requested Drug

<b>FABRAZYME</b>	<b>Reason for Request</b>			
<b>Condition/Diagnosis Related</b>				

#### Clinical Drug/Lab History Pertinent to Request

<b>Labs: Baseline/Ongoing</b>	<b>Strength/Dosage</b>
<b>Formulary Alternative(s) Attempted?</b>	<b>Yes:</b> <input type="checkbox"/> <b>No:</b> <input type="checkbox"/>
<b>Please List Alternative Formulary Drugs</b>	

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

**Fax Form to 1-866-481-3704**