

Sterling Retiree Rx Prior Authorization Form

NAGLAZYME

Coverage Criteria / Required Medical Information

Diagnosis confirmed by an enzymatic assay showing a deficiency in N-acetylgalactosamine activity or DNA testing.

Must have at least one MPS VI symptom.

For re-authorization, must demonstrate improvement in walking and/or stair-climbing capacity.

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

NAGLAZYME	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