



Optum Specialty Phone: 855-427-4682
Optum Specialty Fax: 877-342-4596

Enzyme Replacement Therapy/ Lysosomal Storage Disease Enrollment Form

Specialty Pharmacy Enrollment Form

Please detach before submitting to a pharmacy – tear here.

PATIENT INFORMATION

Please complete the following or **send patient demographic sheet**

Patient Name _____
Address _____
Address 2 _____
City, State, ZIP _____
Home Phone _____ Alternate Phone _____
DOB _____ Last Four of SS# _____ Gender _____
Language Preference: English Spanish Other _____

PRESCRIBER INFORMATION

Prescriber's Name _____
DEA _____
NPI _____
Group/Hospital _____
Address _____
City, State, ZIP _____
Phone _____ Fax _____
Contact Person _____ Phone _____

INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides)

Prior Authorization Reference number _____

MEDICAL INFORMATION (Section must be completed to process prescription) (Please supply pertinent clinical data for prior authorizations. Attach separate sheet if needed)

Diagnosis — Please include diagnosis name with ICD-10 code

- | | |
|--|--|
| <input type="checkbox"/> E74.00 Glycogen storage disease, unspecified | <input type="checkbox"/> E74.01 von Gierke disease |
| <input type="checkbox"/> E74.04 McArdle disease | <input type="checkbox"/> E74.09 Other glycogen storage disease _____ |
| <input type="checkbox"/> E75.21 Fabry (-Anderson) disease | <input type="checkbox"/> E75.22 Gaucher disease |
| <input type="checkbox"/> E75.249 Niemann-Pick disease, unspecified | <input type="checkbox"/> E76.01 Hurler's Syndrome |
| <input type="checkbox"/> E76.03 Scheie's Syndrome | <input type="checkbox"/> E76.1 Mucopolysaccharidosis, type II |
| <input type="checkbox"/> E76.219 Morquio Mucopolysaccharidosis, unspecified | <input type="checkbox"/> E76.22 Sanfilippo Mucopolysaccharidosis |
| <input type="checkbox"/> E76.29 Other Mucopolysaccharidosis _____ | |
| <input type="checkbox"/> E76.3 Mucopolysaccharidosis, unspecified | |
| <input type="checkbox"/> E77.0 Defects in post-translational modification of lysosomal enzymes | |
| <input type="checkbox"/> E77.1 Defects in glycoprotein degradation | |
| <input type="checkbox"/> Other Diagnosis: ICD-10 Code _____ Description _____ | |
- Date of Diagnosis _____
Start Date _____ Review Date _____ Next Infusion Date _____

Additional Information

Therapy: New Reauthorization Restart
Weight _____ kg/lbs
Height _____ cm/in
Allergies _____
Lab Data _____
Concomitant Medications _____

Additional Comments _____

PRESCRIPTION INFORMATION

Medication	Dose / Strength	Directions	Quantity	Refills
<input type="checkbox"/> Aldurazyme®	<input type="checkbox"/> 2.9mg Vial with Albumin	_____ mg/kg IV Body Weight Every _____ Days		
<input type="checkbox"/> Cerdelga®	<input type="checkbox"/> 84mg Capsule	<input type="checkbox"/> Once Daily <input type="checkbox"/> Twice Daily		
<input type="checkbox"/> Cerezyme®	<input type="checkbox"/> 200 Unit Vial <input type="checkbox"/> 400 Unit Vial	_____ Units/kg IV Body Weight Every _____ Days		
<input type="checkbox"/> Elaprase®	<input type="checkbox"/> 6mg Vial	_____ mg/kg IV Body Weight Every _____ Days		
<input type="checkbox"/> Fabrazyme®	<input type="checkbox"/> 5mg Vial <input type="checkbox"/> 35mg Vial	_____ mg/kg IV Body Weight Every _____ Days		
<input type="checkbox"/> Lumizyme®	<input type="checkbox"/> 50mg Vial	_____ mg/kg IV Body Weight Every _____ Days		
<input type="checkbox"/> VPRIV®	<input type="checkbox"/> 200 Unit Vial <input type="checkbox"/> 400 Unit Vial	_____ Units/kg IV Body Weight Every _____ Days		

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to: Patient Office Other _____ Date _____ Needs by Date _____
 Product Substitution permitted Dispense as Written

Prescriber's Signature _____ Date _____ Supervising Physician Signature: _____ Date _____
Electronic or digital signatures not accepted.

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone. This form is not a valid prescription in Arizona.