

## Prescriber Criteria Form

Aldurazyme 2026 PA Fax 573-A v1 010126.docx  
Aldurazyme (laronidase)  
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Aldurazyme (laronidase).

Drug Name:  
Aldurazyme (laronidase)

**Patient Name:**

Patient ID:

Patient DOB:

Prescriber Name:

**Prescriber Address:**

**City:**

**State:**

Zip:

## Prescriber Phone:

## Diagnosis:

**Please circle the appropriate answer for each question.**

1	Does the patient have a diagnosis of mucopolysaccharidosis I (MPS I)? [If no, then no further questions.]	Yes	No
2	Was the diagnosis confirmed by an enzyme assay demonstrating a deficiency of alpha-L-iduronidase enzyme activity and/or by genetic testing? [If no, then no further questions.]	Yes	No
3	Does the patient have Hurler (i.e., severe) or Hurler-Scheie (i.e., intermediate or attenuated) form of Mucopolysaccharidosis I (MPS I)? [If yes, then no further questions.]	Yes	No
4	Does the patient have Scheie (i.e., attenuated) form of Mucopolysaccharidosis I (MPS I) with moderate to severe symptoms?	Yes	No

Comments: \_\_\_\_\_

**Prescriber (or Authorized) Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_