

Health New England
Medication Request Form (MRF)/Prescription Request
Fabrazyme[®] (agalsidase beta)

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Prior Authorization

- Prior Authorization Only**
- Prior Authorization and Drug Delivery Request**

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Fabrazyme[®]. Please complete this form and fax to ICORE Healthcare at **(866)-364-2673**. If you have any questions regarding this process, please contact ICORE Healthcare at (800) 775-5138.

Medication Request Information (please complete each section of this form prior to transmittal):

J-code = J0180, 1 unit = 1 mg

Patient Information (all required)	Physician Information (all required)
Patient Name:	Physician Name:
	Specialty:
Patient Cell Phone #: () -	NPI #:
Patient HNE ID#:	HNE Provider #:
Patient Date of Birth:	DEA # :
Allergies:	Telephone #: () -
	Fax # : () -

Drug Information

Requested Drug/Strength/Form: Fabrazyme[®]		
Dose, Directions, and length of treatment (please be specific):	Quantity (per month):	Refills:
Physician Signature:	Date:	

Indication:

- Classic Fabry Disease (male)
- Fabry Disease in heterozygote female

Documentation of Medical Necessity (please check all that apply):

- Patient is under the care of a nephrologist, cardiologist, or other type of physician specializing in metabolic or genetic disorders.
- If patient is a male then the diagnosis been made using alpha galactosidase A enzyme assay.
- Patient has experienced clinical manifestations of the disease (please describe): _____
- Request is for continuation of therapy.
- Patient has demonstrated a response to therapy (please describe): _____

Other Pertinent History (relative or pertaining to this request):