

TEXAS HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID/CHIP VENDOR DRUG PROGRAM

Statement of Medical Necessity
Enzymes

Complete all items or the form will be returned for additional information.
Please document reason why any information is not available.

Client Name: _____ **Medicaid ID#:** _____
Address: _____ **Date of Birth:** _____
_____ **Gender:** Male Female

Instructions: list diagnosis and ICD-9 code for the following medications.

Note: all requests must include the diagnosis and ICD-9 code. Authorizations are good for one year.

<input type="checkbox"/> Aldurazyme Mucopolysaccharidosis I MPS-I Hurler-Scheie syndrome 277.5
<input type="checkbox"/> Adagen Severe combined immunodeficiency disease 279.2
<input type="checkbox"/> Ceprotin Severe congenital Protein C deficiency 280-289
<input type="checkbox"/> Cerezyme Type 1 Gaucher disease 272.7
<input type="checkbox"/> Cinryze Hereditary Angioedema 708
<input type="checkbox"/> Elaprase Mucopolysaccharidosis MPS-II/Hunter syndrome 277.5
<input type="checkbox"/> Fabrazyme Fabry disease 272.7
<input type="checkbox"/> Myozyme Glycogen storage disorder/Pompe disease 271.0
<input type="checkbox"/> Naglazyme Maroteaux-Lamy syndrome 277.5
<input type="checkbox"/> Zelboraf Metastatic melanoma Stage IIIC or Metastatic 172

PHYSICIAN SECTION MUST BE COMPLETED

Name: _____	Tx. License #: _____
Address: _____	Phone: _____
_____	Fax: _____

I certify that the above-indicated therapy is medically necessary, and the information provided is accurate to the best of my knowledge.

Physician Signature: _____ **Date** _____

FORM SUBMITTAL INSTRUCTIONS

Drug Use Review (H-630)
HHSC Medicaid/CHIP Vendor Drug Program
PO Box 85200, Austin, Texas 78708-5200
Fax: 512-491-1962