

## PHYSICIAN'S STATEMENT OF MEDICAL NECESSITY (SMN) FOR NAGLAZYME™ (GALSULFASE) TREATMENT

Phone 1-866-906-6100      Facsimile 1-888-863-3361      [bpps@bmrn.com](mailto:bpps@bmrn.com)

### PATIENT INFORMATION

Name (First & Last): \_\_\_\_\_ Date of Birth (MM/DD/YY): \_\_\_\_\_ Male  Female   
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_  
 Contact Name: \_\_\_\_\_ email: \_\_\_\_\_

### INSURANCE INFORMATION

*Please attach an enlarged copy of both sides of insurance card(s). If not available, fill out completely.*

**Change of Insurance**

#### Primary

HMO  PPO  POS  Indemnity  Separate Rx Card

Insurance: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Subscriber: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Subscriber ID#: \_\_\_\_\_  
 Policy/Group #: \_\_\_\_\_

#### Secondary

HMO  PPO  POS  Indemnity  Separate Rx Card

Insurance: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Subscriber: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Subscriber ID#: \_\_\_\_\_  
 Policy/Group #: \_\_\_\_\_

### DIAGNOSIS AND OTHER RELEVANT MEDICAL INFORMATION

**Diagnosis:** Mucopolysaccharidosis VI (MPS VI) ICD-9 277.5  
**Method of Diagnosis:** Enzyme Assay Activity: \_\_\_\_\_ Leucocytes  Plasma  Skin Fibroblasts   
 Urinary GAG: \_\_\_\_\_ µg/mg creatinine:  
 Date of Diagnosis: \_\_\_\_\_ Lab Performing Diagnosis: \_\_\_\_\_  
 Preferred Infusion Site: \_\_\_\_\_ Contact Name/Phone: \_\_\_\_\_

### PRESCRIPTION INFORMATION

**Prescription Type:**  New Start  Continuing Therapy  Restart  **Drug Allergies:** \_\_\_\_\_  **NKDA**

**Weight:** \_\_\_\_\_  kg  lbs      **Height:** \_\_\_\_\_  cm  inches  
**Dose:**  1 mg/kg  Other (specify) \_\_\_\_\_  
**Frequency:**  Weekly  Other (specify) \_\_\_\_\_  
**Dispense:**  4 Weeks  12 weeks      **Refill** \_\_\_\_\_ **times or through** \_\_\_\_\_ **(date)**

**Physicians Full Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_  
**Tax ID #:** \_\_\_\_\_ **DEA #:** \_\_\_\_\_ **License #:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_  
**Contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **eMail:** \_\_\_\_\_

**I certify that Naglazyme therapy for MPS VI is necessary for this patient. I will be supervising the patient accordingly.**

By signing below, I certify that (a) the above therapy is medically necessary, (b) I have received the necessary authorization to release the above referenced information and other protected health information (as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to BPPS and contracted dispensing pharmacy or other contractors for the purpose of seeking reimbursement, assisting in initiating or continuing therapy, and (c) I appoint BPPS solely to convey on my behalf to the pharmacy chosen by the above-named patient the prescription described herein.

Prescriber's Signature\*: \_\_\_\_\_ Date: \_\_\_\_\_

\*This form cannot be processed without prescriber's signature and a signed PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION form

**Instructions: Filling out the Statement of Medical Necessity (SMN)  
for Naglazyme™ (Galsulfase) treatment**

Phone 1-866-906-6100

Facsimile 1-888-863-3361

[bpps@bmrn.com](mailto:bpps@bmrn.com)**Attach to completed SMN**

- A signed PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION form
- Most current office visit note and treatment plan

**Patient Information**

- Please list patient and contact information (if applicable)

**Insurance information**

- If you fax copies of both sides of the patient's insurance card(s), please make sure that they are enlarged enough so that all of the information is readable (especially the ID#, contact phone number, and address)
- Please fax a copy of the Rx card (if available)
- **Change of Insurance:** Check this box if reporting new insurance information

**Diagnosis and other relevant medical information**

- Please include method, date, and laboratory confirming diagnosis of MPS VI

**Prescription information**

- **Prescription Type:** Check the box that applies. A New Start is a patient who has never been on Naglazyme. Continuing Therapy is a patient who is continuing therapy *without* interruption. A restart is a patient who is starting therapy *after* an interruption
- **Dose:** The recommended dosage regimen of Naglazyme is 1 mg/kg of body weight administered once weekly as an intravenous infusion\*
- **Dispense:** Please check the box that applies and include refill instructions
- **Physician Information:** Please fill-in the prescribing physicians full name, DEA and License #s as well as office address, phone, fax, and email (if available). Add information for any other appropriate office contact individuals

**REMINDER:** This form cannot be processed without a prescriber's signature and a signed PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION form.

\*Refer to full prescribing information available at [www.naglazyme.com](http://www.naglazyme.com) for additional product-related detail