STATEMENT OF MEDICAL NECESSITY

FOR THE TREATMENT OF MUCOPOLYSACCHARIDOSIS I DISEASE

Patient Information

Patient's Name _____ **Address** _____

Date of Birth _____ **City** _____ **State** _____ **Zip** _____

Gender: Male___Female_____ **Phone No. (Home)** _____

Phone No. (Work) _____

Parent/Legal Guardian Name (If applicable) _____

Insurance Information

Insurance Co _____ **Policyholder's Name** _____

Policy Number _____ **Group Number** _____

Insurance Phone _____

Diagnosis

Mucopolysaccharidosis I (MPS I)

ICD-10-CM ☐ E76.01 Hurler Syndrome ☐ E76.02 Hurler Scheie Syndrome ☐ E76.03 Scheie Syndrome

Method of diagnosis: Enzyme Assay Activity _____ ☐ leukocytes ☐ plasma ☐ skin fibroblasts
Urinary GAG _____ µg/mg creatinine

Date of Diagnosis _____ Lab performing Diagnosis _____

Medical Assessment

Weight _____ kg Height _____ Inches Head Circumference _____ Inches

Symptoms consistent with MPS I (Please List)

_____

_____

_____

_____

_____

_____

Treatment Recommendation

Dose _____ **mg/kg** **Frequency** _____

Therapy Start Date _____/____/____ Frequency of follow-up evaluation _____ months ____ weeks

Please list any additional treatment information:

_____

_____

_____

_____

Physician Authorization

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

Physician Name (printed) _____ Date _____

Address _____ City _____ State _____ ZIP

Phone _____ _____ Fax _____

_____

Physician's Signature _____ **Medical License #** _____

State Issued _____