



Prior Authorization Approval Criteria

Aldurazyme (laronidase)

Generic name:	laronidase
Brand name:	Aldurazyme
Medication class:	Mucopolysaccharidosis I agent
FDA-approved uses:	Laronidase is indicated for patients with Hurler and Hurler-Scheie forms of mucopolysaccharidosis I (MPS I) and for patients with the Scheie form that have moderate-to-severe symptoms.
Usual dose:	0.58 mg/kg administered once weekly (intravenous infusion) over 3-4 hours.
Duration of therapy:	Indefinite

Criteria for use (*bullet points below are all inclusive unless otherwise noted*):

- Clinically documented MPS I
- Physician must provide goals of therapy.
- Physician must provide patient's baseline disease status.

Criteria for continuation of therapy:

- Physician must provide update of patient's baseline disease status.

Not approved if:

- The above guidelines for approval are not met

Special considerations:

- Patient will be referred to high-risk case management.
- Initial approval is for 3 months; can then be extended for up to one year

FCHP Pharmacy and Therapeutics Committee approval: _____

Date: _____

Adopted: 11/12/2004