

APPLICANT (stamp or sticker acceptable) **PATIENT NHI:** **REFERRER** Reg No:

Reg No: First Names: First Names:

Name: Surname: Surname:

Address: DOB: Address:

..... Address:

.....

Fax Number: Fax Number:

Idursulfase

Initial application
Applications only from a metabolic physician. Approvals valid for 24 weeks.
Prerequisites(tick boxes where appropriate)

The patient has been diagnosed with Hunter Syndrome (mucopolysaccharidosis II)

and

Diagnosis confirmed by demonstration of iduronate 2-sulfatase deficiency in white blood cells by either enzyme assay in cultured skin fibroblasts

or

Detection of a disease causing mutation in the iduronate 2-sulfatase gene

and

Patient is going to proceed with a haematopoietic stem cell transplant (HSCT) within the next 3 months and treatment with idursulfase would be bridging treatment to transplant

and

Patient has not required long-term invasive ventilation for respiratory failure prior to starting Enzyme Replacement Therapy (ERT)

and

Idursulfase to be administered for a total of 24 weeks (equivalent to 12 weeks pre- and 12 weeks post-HSCT) at doses no greater than 0.5 mg/kg every week

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:
Post application to Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz