

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

Reg No: .....      First Names: .....      First Names: .....

Name: .....      Surname: .....      Surname: .....

Address: .....      DOB: .....      Address: .....

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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](mailto:customerservice@health.govt.nz)