

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