

Statement of Medical Necessity

Treatment of Juvenile or Perinatal/infantile onset Hypophosphatasia (HPP)

Phone: 1-844-787-6747 (ext 8006)

Fax: 1-844-787-2527

Patient Demographics

Name _____ Date of Birth ____/____/____ Age _____
 Address _____ City _____ Zip _____
 Gender Male Female
 Phone No. (home) _____ Phone No. (cell) _____
 Parent/Guardian _____ Relation to child _____ Phone _____

Insurance Information

Insurance Co. _____ Policy No. _____ Insurance Phone No. _____
 Insurance Co. _____ Policy No. _____ Insurance Phone No. _____

Please provide the following HPP Laboratory Value and Report: Alkaline Phosphatase (ALP) _____

Diagnosis

Hypophosphatasia Dx: Date _____ Date of Onset of First Symptom of HPP ____/____/____
 (see table below for a list of common symptoms/complications of HPP)

The Following Symptoms and Complications Can Be Involved with HPP

	History of / currently has:	Onset < age 18		History of / currently has:	Onset < age 18
Skeletal			Muscular/Rheumatologic		
Hypomineralization	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Skeletal Deformities	<input type="checkbox"/>	<input type="checkbox"/>	Hypotonia	<input type="checkbox"/>	<input type="checkbox"/>
Fractures	<input type="checkbox"/>	<input type="checkbox"/>	Muscle / joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Craniosynostosis	<input type="checkbox"/>	<input type="checkbox"/>	Waddling gait	<input type="checkbox"/>	<input type="checkbox"/>
Rachitic chest	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Walking	<input type="checkbox"/>	<input type="checkbox"/>
Rickets	<input type="checkbox"/>	<input type="checkbox"/>	Neurologic		
Bowing	<input type="checkbox"/>	<input type="checkbox"/>	Vitamin B ₆ -responsive seizures	<input type="checkbox"/>	<input type="checkbox"/>
Bone Pain	<input type="checkbox"/>	<input type="checkbox"/>	Increased intracranial pressure	<input type="checkbox"/>	<input type="checkbox"/>
Osteomalacia	<input type="checkbox"/>	<input type="checkbox"/>	Growth / Development		
Respiratory			Failure to Thrive	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Insufficiency	<input type="checkbox"/>	<input type="checkbox"/>	Delayed/missed motor milestones	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Failure	<input type="checkbox"/>	<input type="checkbox"/>	Short Stature	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Support	<input type="checkbox"/>	<input type="checkbox"/>	Functional Disabilities		
Dental			Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>
Premature tooth loss < age 5	<input type="checkbox"/>	<input type="checkbox"/>	Uses Walking Device	<input type="checkbox"/>	<input type="checkbox"/>
Premature or nontraumatic tooth loss	<input type="checkbox"/>	<input type="checkbox"/>			

Healthcare Provider

I verify that the patient prescriber information contained in this enrollment form is complete and accurate to the best of my knowledge and based on my professional judgement of medical necessity.

Provider's name (printed) _____ Date ____/____/____
 Address _____ City _____ State _____ Zip _____
 Phone _____ Provider's Signature _____
 Fax# _____ Email Address _____
 License Number _____ NPI Number _____

PLEASE ATTACH COPIES OF RECENT LAB REPORTS

US/UNB-HPP/16/0128(1)