Statement of Medical Necessity

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

Phone: 1-888-765-4747
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
Skeletal		
Hypomineralization	☐	☐
Skeletal Deformities	☐	☐
Fractures	☐	☐
Craniosynostosis	☐	☐
Rachitic chest	☐	☐
Rickets	☐	☐
Bowing	☐	☐
Bone Pain	☐	☐
Osteomalacia	☐	☐
Respiratory		
Respiratory Insufficiency	☐	☐
Respiratory Failure	☐	☐
Respiratory Support	☐	☐
Dental		
Premature tooth loss < age 5	☐	☐
Premature or nontraumatic tooth loss	☐	☐

	History of / currently has:	Onset < age 18
Muscular/Rheumatologic		
Muscle Weakness	☐	☐
Hypotonia	☐	☐
Muscle / joint pain	☐	☐
Waddling gait	☐	☐
Difficulty Walking	☐	☐
Neurologic		
Vitamin B_6-responsive seizures	☐	☐
Increased intracranial pressure	☐	☐
Growth / Development		
Failure to Thrive	☐	☐
Delayed/missed motor milestones	☐	☐
Short Stature	☐	☐
Functional Disabilities		
Wheelchair	☐	☐
Uses Walking Device	☐	☐

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

9/1/2016