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. _____

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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	☐	☐	Muscle Weakness	☐	☐
Skeletal Deformities	☐	☐	Hypotonia	☐	☐
Fractures	☐	☐	Muscle / joint pain	☐	☐
Craniosynostosis	☐	☐	Waddling gait	☐	☐
Rachitic chest	☐	☐	Difficulty Walking	☐	☐
Rickets	☐	☐	**Neurologic**		
Bowing	☐	☐	Vitamin B_6-responsive seizures	☐	☐
Bone Pain	☐	☐	Increased intracranial pressure	☐	☐
Osteomalacia	☐	☐	**Growth / Development**		
Respiratory			Failure to Thrive	☐	☐
Respiratory Insufficiency	☐	☐	Delayed/missed motor milestones	☐	☐
Respiratory Failure	☐	☐	Short Stature	☐	☐
Respiratory Support	☐	☐	**Functional Disabilities**		
Dental			Wheelchair	☐	☐
Premature tooth loss < age 5	☐	☐	Uses Walking Device	☐	☐
Premature or nontraumatic tooth loss	☐	☐			

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 _____

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