Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax#: _____ Pharmacy Name: _____ Pharmacy Phone: _____

Horizon NJ Health

Elosulfase Alfa (Vimizim) – Medical Necessity Request

*****Complete page 1 for Initial Requests Only*****

General Questions:

1. What is the member's current weight? _____ lbs or _____ kg

2. Does the member have a diagnosis of Mucopolysaccharidosis IV type A (MPS IVA, Morquio A syndrome)? **Yes** or **No**

3. Please indicate which of the following confirmed the diagnosis of Mucopolysaccharidosis IV type A (MPS IVA, Morquio A syndrome):
   - □ Genetic Testing
   - □ Absence or deficiency in N-acetylgalactosamine 6-sulfatase (GALNS) enzyme activity
   - □ None of the above

4. Does the member have documented clinical signs and symptoms of Morquio A syndrome (e.g., kyphoscoliosis, pectus carinatum, knee deformity, etc.)? **Yes** or **No**

5. Is the medication being prescribed by or in consultation with an endocrinologist, geneticist, metabolic disorders specialist, or an expert in the disease? **Yes** or **No**

6. Will the medication be administered under the supervision of a healthcare professional with the capability to manage anaphylaxis? **Yes** or **No**

7. ***NOTE***: Progress notes indicating progressive improvement with treatment (e.g, distance walked in six minutes (6-MWT), etc.), compared to baseline testing and/or clinical assessments to assess response to therapy will be required for subsequent requests.

Physician office's signature*_____ Print Name_____

***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax#: _____ Pharmacy Name: _____ Pharmacy Phone: _____

Horizon NJ Health

Elosulfase Alfa (Vimizim) – Medical Necessity Request

*****Complete page 2 only for Subsequent/Renewal requests*****

1. What is the member's current weight? _____ lbs or _____ kg

2. Are there progress notes indicating progressive improvement with treatment (e.g, distance walked in six minutes (6-MWT), etc.), compared to baseline testing and/or clinical assessments to assess response to therapy? **Yes** or **No**

Physician office's signature*_____ Print Name_____

***Form must be completed and signed by physician or licensed representative from the physician's office**