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

Drug Name: _____ Strength: _____ Directions: _____

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

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

Horizon NJ Health

Vestronidase alfa-vjbk (Mepsevii®) – Medical Necessity Request

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

General Questions:

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

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

3. Does the member have a documented diagnosis of Mucopolysaccharidosis VII (MPS VII, Sly syndrome)? **Yes** or **No**

4. Please indicate which of the following confirmed the diagnosis of Mucopolysaccharidosis VII (MPS VII, Sly syndrome)
   - □ Detection of mutations in the beta-glucuronidase (GUSB) gene
   - □ Beta-glucuronidase (GUS) enzyme deficiency in peripheral blood leukocytes or fibroblasts
   - □ None of the above

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

6. ***NOTE***: Progress notes indicating progressive improvement with treatment (e.g., distanced 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

Vestronidase alfa-vjbk (Mepsevii®) – 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**