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

Drug Name: _____ Strength: _____ Directions: _____

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

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

Horizon NJ Health

Nitisinone (Nityr, Orfadin) – Medical Necessity Request

Complete page 1 for initial requests and page 2 for subsequent

Diagnosis Information (please indicate diagnosis and answer related questions):

□ Hereditary Tyrosinemia (HT-1)

- Has the member's diagnosis confirmed by one of the following and if so, please specify which one(s)?
  - □ Genetic testing confirmed a mutation of the fumarylacetoacetate hydrolase (FAH) gene
  - □ Elevated serum levels of alpha-fetoprotein (AFP) and succinylacetone
  - □ Diagnosed with HT-1 by the presence of succinylacetone in the urine or plasma
  - □ None of the above

□ Other, please specify _____

General Questions:

1. Will the medication be prescribed in conjunction with a tyrosine and phenylalanine restriction diet? **Yes or No**
2. Will the member be taking Nityr and Orfadin concurrently? **Yes or No**
3. Is the medication prescribed by or in consultation with a provider who has expertise in this disease? **Yes or No**
4. What is the member's current weight? _____lbs or _____kg
5. Will the member's platelet and white blood cell counts be monitored during 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**

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

Drug Name: _____ Strength: _____ Directions: _____

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

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

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

Diagnosis Information (please indicate diagnosis and answer related questions):

□ Hereditary Tyrosinemia (HT-1)

1. Has the member experienced documented disease stabilization or improvement from baseline? **Yes or No**
2. Is the member tolerating treatment? **Yes or No**
3. What is the member's current weight? _____lbs or _____kg

□ Other:_____

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**