Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: ______________________________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: ______________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

Horizon NJ Health

Elapegademase-Lvlr (Revcovi) – Medical Necessity Request

Complete page 1 for initial requests and page 2 for subsequent

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

□ Adenosine deaminase severe combined immune deficiency (ADA-SCID)

- Has the member's diagnosis been confirmed by one of the following and if so, please specify which one(s)?
  - □ Genetic testing confirming biallelic mutation in the adenosine deaminase (ADA) gene
  - □ Member meets both of the following:
    - Elevated deoxyadenosine triphosphate (dATP) levels in erythrocyte lysates compares to laboratory standard
    - Absent or very low (<1% of normal) adenosine deaminase (ADA) activity in red blood cells, which is accompanied by increased levels of adenosine
  - □ None of the above

□ Other, please specify ____

General Questions:

1. Is the medication prescribed by or in consultation with an immunologist, hematologist/oncologist, or a physician who is an expert in adenosine deaminase severe combined immune deficiency (ADA-SCID) or related disorders? **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):

□ Adenosine deaminase severe combined immune deficiency (ADA-SCID)

1. Has the member experienced a positive clinical response to Revcovi as demonstrated by at least one of the following and if so, please specify which one(s)?
   □ Member has maintained adequate trough plasma adenosine deaminiase (ADA) activity levels
   □ Member has maintained adequate deoxyadenosine levels, and/or total lymphocyte counts
   □ Member has decreased the frequency of infections
   □ None of the above

□ Other:__________________________________

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