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

Drug Name: _____ Strength: _____ Directions: _____

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

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

Horizon NJ Health

Voretigene neparvovec-rzyl (Luxturna®) – Medical Necessity Request

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

□ Retinal dystrophy

- □ Does the member have a diagnosis of confirmed biallelic RPE65 mutation-associated retinal dystrophy?

□ Other, please specify _____

General Questions:

1. Does the member have viable retinal cells as determined by the treating physician(s) ? **Yes or No**
2. Is the medication prescribed by or in consultation with an ophthalmologist? **Yes or No**
3. Has the member previously been treated with Voretigene neparvovec-rzyl (Luxturna®) in the requested treatment eye(s) ? **Yes or No**
4. Has the member received intraocular surgery within prior 6 months? **Yes or No**
5. Will the medication be administered to each eye on separate days within a close interval, but no fewer than 6 days apart? **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**