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

Drug Name: _____ Strength: _____ Directions: _____

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

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

Horizon NJ Health
Lumizyme and Nexviazyme – Medical Necessity Request
Complete page 1 for Initial Requests Only

1. Does the member have a diagnosis Pompe disease?
   □ **No** - what is the member's diagnosis? _____
   □ **Yes** – please indicate the onset type and answer the related questions:

   □ **Infantile onset** – which of the following confirmed the diagnosis?
   □ Absence or deficiency (< 1% of the lab specific normal mean) acid alpha-glucosidase deficiency activity in fibroblasts, lymphocytes, or muscle
   □ Increased lysosomal glycogen
   □ Molecular genetic testing for deletion or mutation in the GAA gene

   □ **Late-onset (non-infantile)** – which of the following confirmed the diagnosis?
   □ Absence or deficiency (< 40% of the lab specific normal mean) GAA activity in lymphocytes, fibroblasts, or muscle
   □ Increased lysosomal glycogen
   □ Molecular genetic testing for deletion or mutation in the GAA gene

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

3. What is the member's current weight taken within the past 4 weeks? _____lbs or _____ kg

4. Will the member be receiving Nexviazyme together with Lumizyme? **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: _____

Horizon NJ Health
Lumizyme and Nexviazyme – Medical Necessity Request
****Complete page 2 only for Subsequent/Renewal requests****

5. Has the member experienced a positive clinical response to therapy (e.g., improved cardiac/respiratory function etc.)? **Yes or No**

6. Will the member be receiving Nexviazyme together with Lumizyme? **Yes or No**

7. Please let us know the member's current weight: ____ lbs or ____kg

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