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

Drug Name: _____ Strength: _____ Directions: _____

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

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

Horizon NJ Health

Gaucher Disease Products – Medical Necessity Request

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

General Questions:

1. What is the member's current weight? _____ lbs or _____ kg Date: _____
2. What is the member's current height? _____ inches or _____ cm Date: _____

For Cerdelga:

1. Has the member been tested for CYP2D6 Metabolizing status with an FDA-cleared test? **Yes** or **No**
   - If Yes, What type of metabolizer is the member? □ Poor □ Intermediate □ Extensive
2. Please answer following based on the type of metabolizer the member is:

For Extensive Metabolizer	**For Intermediate Metabolizer**	**For Poor Metabolizer**
□ Taking a strong or moderate CYP2D6 inhibitor concomitantly with a strong or moderate CYP3A inhibitor □ Moderate to Severe Hepatic impairment □ Mild Hepatic impairment taking a strong or moderate CYP2D6 inhibitor □ None	□ Taking a strong or moderate CYP2D6 inhibitor concomitantly with a strong or moderate CYP3A inhibitor □ Taking a strong CYP3A inhibitor □ Any degree of Hepatic impairment □ None	□ Taking a strong CYP3A inhibitor □ Any degree of Hepatic impairment □ None

For all drugs:

1. What is the member's diagnosis? □ Gaucher Disease □ Other, please specify _____
2. For Gaucher Disease, what type does the member have? □ Type 1 □ Type 3 □ Other _____
3. For Gaucher disease, has the diagnosis been confirmed by the following?
   - □ Beta-glucosidase leukocyte (BGL) test
   - □ Genotype testing indicating mutation of two alleles of the glucocerebrosidase genome (i.e., GBA gene)
   - □ None of the above
4. Does the member exhibit clinical signs and symptoms of the disease including anemia, thrombocytopenia, skeletal disease, hepatomegaly or splenomegaly? **Yes** or **No**
5. Is the drug being prescribed by or in consultation with a hematologist, neurologist or geneticist? **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

1. What is the member's diagnosis? □ Gaucher Disease □ Other, please specify _____
2. What is the dose requested? _____
3. What was the previous dose? _____
4. What is the member's current weight? _____ lbs or _____ kg
5. What is the member's current height? _____ inches or _____ cm
6. Is there documentation that the member has experienced a positive clinical response to medication (e.g. reduced severity of symptoms)? **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**