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

Drug Name: _____________________________ Strength: _______________ Directions: ____________________________________

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

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

Horizon NJ Health

Lambert-Eaton Myasthenic Syndrome (LEMS) 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: __________________

3. Is the requested medication prescribed by or in consultation with a neurologist, pediatric neurologist, or a neuromuscular specialist? **Yes** or **No**

4. Does the member have a documented diagnosis of Lambert-Eaton Myasthenic Syndrome (LEMS)? **Yes** or **No**
   - If No, what is the diagnosis? ____

5. Please indicate which of the following confirmed the diagnosis of LEMS
   - □ Electrodiagnostic study (e.g., repetitive nerve stimulation)
   - □ Anti-P/Q-type voltage-gated calcium channels antibody testing
   - □ None of the above

6. Does the member have documentation of baseline clinical muscle strength assessment for one of the following?
   - □ Quantitative Myasthenia Gravis (QMG) score
   - □ Triple-Timed Up-and-Go test (3TUG)
   - □ Timed 25-foot Walk test (T25FW)
   - □ None of the above

7. Does the member have history of seizures? **Yes** or **No**

8. Does the member have an end stage renal disease (Creatinine clearance less than 15mL/min, on dialysis, or post renal transplant)? **Yes** or **No**

9. What other drugs will the member be receiving with the requested drug? ____
   ____

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 current weight? ______ lbs or _________ kg Date: __________________
2. What is the member's current height? ______ inches or _______ cm Date: __________________
3. What is the diagnosis? ____
4. Does the member have documentation of positive clinical response to therapy as evidenced by one of the following clinical muscle strength assessment?
   - ◻ Quantitative Myasthenia Gravis (QMG) score
   - ◻ Triple-Timed Up-and-Go test (3TUG)
   - ◻ Timed 25-foot Walk test (T25FW)
   - ◻ None of the above
5. Does the member have an end stage renal disease (Creatinine clearance less than 15mL/min, on dialysis, or post renal transplant)? **Yes** or **No**
6. What other drugs will the member be receiving with the requested drug? ____
   ____

Physician office's signature*________________________________ Print Name_______________________________

***Form must be completed and signed by physician or licensed representative from the physician's office**