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

Drug Name: _____ Strength: _____ Directions: _____

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

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

Horizon NJ Health

Fabry 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
2. Is the medication being prescribed by or in consultation with a specialist in genetic disorders? □ **Yes** □ **No**
3. What is the diagnosis? □ Fabry Disease □ Other**:** _____
4. Please indicate which of the following confirmed the diagnosis of Fabry Disease:
   - □ Documentation of complete deficiency or ≤ 5% of mean normal alpha-galactosidase A (α-GAL A) enzyme activity in leukocytes, dried blood spots, or serum (plasma) analysis
   - □ Documented galactosidase alpha mutation by gene sequencing
   - □ None of the above
5. Please indicate which of the following clinical/physical feature(s) the member has that are associated with Fabry Disease:
   - □ Intermittent episodes of burning pain in the extremities (acroparesthesias)
   - □ Cutaneous vascular lesions (angiokeratomas)
   - □ Diminished perspiration (hypo- or anhidrosis)
   - □ Characteristic corneal and lenticular opacities
   - □ Chronic kidney disease (CKD) and/or proteinuria of unknown etiology
   - □ Other: _____
   - □ None

For agalsidase beta (Fabrazyme) requests, please answer the following:

1. Is the member 8 years or older? □ **Yes** □ **No**
2. Is the member also receiving Galafold? □ **Yes** □ **No**

For migalastat (Galafold) requests, please answer the following:

1. Is the member an adult? □ **Yes** □ **No**
2. Does the member have an amenable galactosidase alpha gene (GLA) variant based on in vitro assay data? □ **Yes** □ **No**
3. Does the member have severe renal impairment or end-stage renal disease requiring dialysis? □ **Yes** □ **No**
4. Is the member also receiving Fabrazyme? □ **Yes** □ **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
Fabry Disease Products – Medical Necessity Request
****Complete page 2 only for Subsequent/Renewal requests****

1. What is the member's current weight? _____ lbs OR _____kg

2. Has the member had a positive clinical response to therapy? □ **Yes** □ **No**

3. Has the member been adherent with the medication? □ **Yes** □ **No**

4. Please indicate which of the following routine lab tests have been performed:
   - □ Complete Blood Count (CBC)
   - □ Estimated glomerular filtration Rate (eGFR)
   - □ Urinalysis, urinary protein-to-creatinine ration, or albumin-to-creatinine ratio
   - □ Basic metabolic panel (BMP)
   - □ None of the above

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