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

Drug Name: _____________________________ Strength: _______________ Directions: ______________________________________

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

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

Horizon NJ Health

Asfotase Alfa (Strensiq) – *Medical Necessity Request*

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

General Questions:

1. Please provide the member's current weight and height:
   Weight: ________ lbs or ________kg Date:__________
   Height: _______ inches or _______cm Date:_________

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

1. What is the diagnosis?

   □ **Perinatal/infantile or Juvenile-onset hypophosphatasia (HPP)**

   a. Does the member have clinical symptoms consistent with hypophosphatasia at the age of onset [e.g. vitamin B6-dependent seizures, skeletal abnormalities such as flawed and frayed metaphysis]? **Yes or No**

   b. Has a molecular genetic test confirmed mutations in the ALPL gene that encodes the tissue nonspecific isoenzyme of ALP (TNSALP)? **Yes or No**

   c. Is there reduced activity of unfractionated serum alkaline phosphatase (ALP) [below the age and gender adjusted normal range]? **Yes or No**

   d. Please indicate if the member has any of the following (check all that apply):

   □ Elevated urine concentration of phosphoethanolamine (PEA)

   □ Elevated serum concentration of pyridoxal 5'-phosphate (PLP) in the absence of vitamin supplements within a week prior to assaying

   □ Elevated urine inorganic pyrophosphate (PPi)

   e. Is the requested medication being prescribed by or in consultation with a physician who specializes in the treatment of inherited metabolic disorders? **Yes or No**

   f. Was baseline ophthalmologic examination and renal ultrasound completed? **Yes or No**

   □ **Other**

   a. What is the diagnosis?

   ____

   ____

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

General Questions:

1. Please provide the member's current weight and height:
   Weight: ________ lbs or ________kg Date:__________
   Height: _______ inches or _______cm Date:_________

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

1. What is the diagnosis?
   □ **Perinatal/infantile or Juvenile-onset hypophosphatasia (HPP)**
   □ **Other**
      a. What is the diagnosis?
      ____
      ____

2. Has the member responded to treatment as demonstrated by an improvement and/or stabilization (e.g. radiographic findings, growth, mobility, respiratory status)? **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**