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

Drug Name: _____________________________ Strength: _______________ Directions: ______________________________________

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

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

Horizon NJ Health

Urea Cycle Disorder Products (Buphenyl, Ravicti, Carbaglu) – Medical Necessity Request

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

General Questions:

1. What is the member's current weight? ____ lbs or ____ kg
2. What is the member's current height? __________
3. Is the medication being prescribed by or in consultation with a geneticist or a physician experienced in treating metabolic disorders? **Yes or No**

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

1. What is the diagnosis?
   a. □ Urea Cycle Disorder
      i. Is the medication being used for the treatment of acute hyperammonemia? **Yes or No**
      ii. Will the medication be used in conjunction with dietary protein restriction? **Yes or No**
   b. □ Treatment of Hyperammonemia due to N-acetylglutamate synthase (NAGS) deficiency
   c. □ Other: ____
2. Was the diagnosis confirmed by enzymatic, biochemical, or genetic testing? **Yes or No**

For Ravicti requests only:

1. Has the member tried sodium phenylbutyrate for this diagnosis? **Yes or No**
   a. If Yes, why was it discontinued?
      ____
   b. If No, why not?
      ____
2. Is the medication being used for treatment of N-acetylglutamate synthase (NAGS) deficiency? **Yes or No**

For Carbaglu requests only:

1. Is the medication being used for the acute hyperammonemia? **Yes or No**
   - If Yes, please let us know if the medication will be used in conjunction with other ammonia lowering therapies (e.g., alternative pathway drugs, hemodialysis, and dietary protein)? **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****

General Information

1. What is the member's current weight? ____ lbs or ____ kg
2. What is the member's current height? __________
3. Is the medication prescribed by or in consultation with a geneticist or a physician experienced in treating metabolic disorders? **Yes or No**
4. ***Please submit lab results within the past 6 months indicating a normal or improved ammonia level***

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

1. What is the diagnosis?
   a. □ Urea Cycle Disorder
      i. Is the medication being used for the treatment of acute hyperammonemia? **Yes or No**
      ii. Will the medication be used in conjunction with dietary protein restriction? **Yes or No**
   b. □ Treatment of Hyperammonemia due to N-acetylglutamate synthase (NAGS) deficiency
   c. □ Other: ____

For Ravicti requests only:

1. Is the medication being used for treatment of N-acetylglutamate synthase (NAGS) deficiency? **Yes or No**

For Carbaglu requests only:

1. Is the medication being used for the acute hyperammonemia? **Yes or No**
   - If Yes, please let us know if the medication will be used in conjunction with other ammonia lowering therapies (e.g., alternative pathway drugs, hemodialysis, and dietary protein)? **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**