

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:

<b>For Extensive Metabolizer</b>	<b>For Intermediate Metabolizer</b>	<b>For Poor Metabolizer</b>
<input type="checkbox"/> Taking a strong or moderate CYP2D6 inhibitor concomitantly with a strong or moderate CYP3A inhibitor <input type="checkbox"/> Moderate to Severe Hepatic impairment <input type="checkbox"/> Mild Hepatic impairment taking a strong or moderate CYP2D6 inhibitor <input type="checkbox"/> None	<input type="checkbox"/> Taking a strong or moderate CYP2D6 inhibitor concomitantly with a strong or moderate CYP3A inhibitor <input type="checkbox"/> Taking a strong CYP3A inhibitor <input type="checkbox"/> Any degree of Hepatic impairment <input type="checkbox"/> None	<input type="checkbox"/> Taking a strong CYP3A inhibitor <input type="checkbox"/> Any degree of Hepatic impairment <input type="checkbox"/> 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