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**