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**