STATEMENT OF MEDICAL NECESSITY

FOR THE TREATMENT OF NEUROLOGICAL MANIFESTATIONS OF GAUCHER DISEASE TYPE 3 IN ADULTS AND PEDIATRIC PATIENTS WEIGHING ≥15 KG

Patient Information

Patient Name:	Street Address:
Date of Birth:	City: State: ZIP:
Gender: ☐ Male ☐ Female	Phone (Home):
	Phone (Work):

Insurance Information

Insurance Co.:	Policy Holder Name:
Subscriber ID No.:	Insurance Phone No.:
Group No.:	

Diagnosis

☐ Gaucher disease type 3 E75.22

Date of Confirmed Diagnosis: _____

Method of Diagnosis: _____

Medical Assessment

Patient Weight: _____ (kg/lb) **Patient Height** _____ (cm/in)

Neurological symptoms (check all that apply)

☐ Gaze palsy ☐ Seizures ☐ Ataxia ☐ Cognitive Impairment ☐ Hyperreflexia

☐ Bulbar dysfunction ☐ Tremors ☐ Hydrocephalus ☐ Dystonia ☐ Myoclonic epilepsy

☐ Other: _____

Describe severity of neurological symptoms (with quantitative assessments if possible): _____

_____

_____

Treatment Recommendation

Infilbray™ (venglustat) ☐ NDC#: 58468-2006-1 (6 mg) ☐ NDC#: 58468-2015-1 (15 mg)

Dose (number of tablets) per kg _____ Frequency: _____ Therapy Start Date: _____

Physician Authorization

I certify that the above-indicated therapy is medically necessary and the information provided is accurate to the best of my knowledge.

Physician Name: _____ Date: _____

Street Address: _____ City: _____ State: ____ ZIP: _____

Phone: _____

Physician Signature: _____

Physician's Medical License No.: _____ State Issued: _____