

# STATEMENT OF MEDICAL NECESSITY

## FOR THE TREATMENT OF NON-CNS MANIFESTATIONS OF GAUCHER DISEASE TYPE 1 AND TYPE 3 IN ADULTS AND PEDIATRIC PATIENTS

### Patient Information

Patient Name:	Street Address:		
Date of Birth:	City:	State:	ZIP:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone (Home):		
Phone (Work):			

### Insurance Information

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

### Medical Assessment

Patient Weight: \_\_\_\_\_ kg/lb Patient Height \_\_\_\_\_ (cm/in))

**Growth Delay**  
 Yes  No Height Percentile: \_\_\_\_\_

Hepatomegaly  Yes  No Date: \_\_\_\_\_ Liver Size: \_\_\_\_\_

Splenomegaly  Yes  No Date: \_\_\_\_\_ Spleen Size: \_\_\_\_\_

**Hematology**  
Anemia  Yes  No Hemoglobin: \_\_\_\_\_  
Thrombocytopenia  Yes  No Platelet Count: \_\_\_\_\_  
Bleeding Event  Yes  No Hematocrit: \_\_\_\_\_

**Neurological involvement:**  Yes  No  
 Supranuclear gaze palsy  Seizures  Cerebellar symptoms  Ataxia  Cognitive Impairment  
Other: \_\_\_\_\_

**Bone Disease**  
(check any or all that apply)  
 Lytic lesion(s)  Osteopenia/Osteoporosis  Marrow infiltration  
 Avascular necrosis  Pathological fracture(s)  Erlenmeyer flask deformity  
 Bone pain/Bone crisis  Infarction(s)  
Other: \_\_\_\_\_

### Diagnosis

<input type="checkbox"/> Gaucher disease type 1 E75.22:	Date of Confirmed Diagnosis: _____
<input type="checkbox"/> Gaucher disease type 3 E75.22	Method of Diagnosis: _____

### Treatment Recommendation

Cerezyme® (imiglucerase)	NDC#: 58468-4663-1 (400U vial)
Dose (number of units 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: \_\_\_\_\_