Statement of Medical Necessity
for the treatment of Type 1 Gaucher Disease

Patient Information

Name (First, Middle Initial, Last) ☐ Male ☐ Female DOB: Month Day Year Parent/Guardian Name (First, Last)

Street Address City State Zip Code

( ) Home Telephone ( ) Work Telephone

Patient Body Weight _____ . _____ kg Height _____ . _____ inches

Insurance Information

Insurance Company Name ( ) Insurance Telephone Policy # Group #

Policy Holder Name (First, Last) Relationship to Patient

Diagnosis and Treatment Rationale

Diagnosis: Gaucher disease ICD-9 272.7 Date Diagnosed: Month Year

Method of Diagnosis: Glucocerebrosidase Assay Activity _____ ☐ Leukocytes ☐ Skin Fibroblasts

Disease History (please check all that apply):

Hematologic:
- ☐ Anemia
- ☐ Bleeding tendencies
- ☐ Ischemia
- ☐ Leukopenia
- ☐ Neutrophil chemotaxis
- ☐ Thrombocytopenia

Skeletal:
- ☐ Avascular necrosis
- ☐ Bone crisis
- ☐ Bone infarction
- ☐ Bone marrow infiltration
- ☐ Bone pain
- ☐ Erlynmeyer flask deformity
- ☐ Joint replacement
- ☐ Lytic bone lesion
- ☐ Necrosis
- ☐ Osteopenia
- ☐ Pathological bone fracture

Visceral:
- ☐ Cirrhosis
- ☐ Hepatic fibrosis
- ☐ Interstitial lung disease
- ☐ Organomegaly
- ☐ Pulmonary hypertension
- ☐ Splenomegaly

Previous treatment(s): _____

Additional comments: _____

Treatment Recommendation: _____ NDC: _ _ _ _ _ - _ _ _ _ - _ _

Dose: _____ Frequency: _____

Physician Information and Authorization

Name (First, Last) State License #

Street Address City State Zip Code

( ) Telephone ( ) Fax

I certify that the rationale for prescribing this treatment is medically necessary and the information provided on this form is accurate to the best of my knowledge.

Physician Signature Date