STATEMENT OF MEDICAL NECESSITY

FOR THE TREATMENT OF GAUCHER DISEASE

Patient Name _____ Insurance ID Number _____

Address _____

Phone Number _____

Gender _____ Date of Birth _____ Weight in kg _____ Height _____

Symptoms of Gaucher Disease First Diagnosed _____ Date _____

Method of Diagnosis _____ Date _____

DIAGNOSIS

☐ Gaucher Disease (Lipidosis) ICD-9CM 272.7 ☐ Gaucher Disease ICD-10-CM E75.22*

SPLENECTOMY

☐ No ☐ Yes: Date _____ Circle One: Total or Partial

ORGANOMEGALY

☐ No ☐ Yes: Spleen Size _____ Liver Size _____

HEMATOLOGY

Anemia	☐ Yes: Hemoglobin	_____
Thrombocytopenia	☐ Yes: Platelet Count	_____
Bleeding Event	☐ Yes: Hematocrit	_____

BONE DISEASE

Lytic lesion(s)	☐ Yes	Joint replacement(s)	☐ Yes
Avascular necrosis	☐ Yes	Osteopenia	☐ Yes
Bone crises	☐ Yes	Pathological fracture(s)	☐ Yes
Bone pain	☐ Yes	Marrow infiltration	☐ Yes
Erlenmeyer flask deformity	☐ Yes	Infarction(s)	☐ Yes
Bleeding Event	☐ Yes		

Other _____

_____

_____

Cerezyme® (imiglucerase for injection) Treatment Plan and Dosing Schedule

(NDC 58468-4663-1 400U vial)

Number of units per kg _____ Frequency _____

Physician Signature _____ Date _____

Address _____

Phone _____ Fax _____

NOTE: This form may not include all information required by your patient's health plan, as requirements will vary based on health plan guidelines and benefit design. Please note that the requesting provider is responsible for ensuring the accuracy, adequacy and supportability of all information provided on this form.

Please see full Prescribing Information attached or available at www.cerezyme.com