STATEMENT OF MEDICAL NECESSITY

FOR THE TREATMENT OF GAUCHER DISEASE

Patient Name				Insurance ID Number			
Address							
Phone Nun	nber						
Gender Date of Birth				_ Weight in k	g He	eight	
Symptoms of Gaucher Disease First Diagnosed				Date			
Method of Diagnosis				Date			
DIAGNOS	SIS						
☐ Gaud	cher Disease	(Lipidosis) ICD-9CM 272.	7	☐ Gauche	er Disease ICD-10-CM E	75.22*	
SPLENEC	тому						
□ No	☐ Yes:	Date			Circle One:	Total or Partial	
ORGANO	DMEGALY						
□ No	☐ Yes:	Spleen Size Liver Size					
НЕМАТО	LOGY						
		Anemia \square] Yes:	Hemoglobin			
				Platelet Coun			
		Bleeding Event]Yes:	Hematocrit			
BONE DIS	SEASE						
		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 deform	nity	□Yes	Infarction(s)	□Yes	
		Bleeding Event		□Yes			
Other							
_							
_	ne® (imiglu 168-4663-1 40	icerase for injection) Tr	eatn	nent Plan an	d Dosing Schedule		
(1400 384	100-4003-1 40	oo viaij					
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.