STATEMENT OF MEDICAL NECESSITY

FOR THE TREATMENT OF GAUCHER DISEASE

Patient Name _____ Insurance ID Number _____

Address _____ City _____ State _____ Zip Code _____

Gender _____ Date of Birth _____ Phone Number _____

Method of Diagnosis _____ Date _____

Prescriber's Last Name _____ Prescriber's First Name _____

Name of Institution/Practice Name _____

Address _____ City _____ State _____ Zip Code _____

Tax ID _____ State License _____ NPI _____

Office Phone _____ Office Fax _____

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

Other_____

_____

CYP2D6 METABOLIZER STATUS

☐ Extensive metabolizers (EM) ☐ Intermediate metabolizers (IM) ☐ Poor metabolizers (PMs)

Additional supporting documentation attached:

☐ Lab Results ☐ Treatment History ☐ Other Clinical Information

CERDELGA™ (eliglustat) CAPSULES TREATMENT PLAN AND DOSING

NDC 58468-0220-1 (56 capsules; 4 packs with 14 capsules each in a carton)

DOSE

☐ 84mg eliglustat twice daily ☐ 84mg eliglustat once daily

Physician Signature _____ Date _____

Please see full Prescribing Information attached to this form and available at www.cerdelga.com