STATEMENT OF MEDICAL NECESSITY

FOR THE TREATMENT OF NON-CENTRAL NERVOUS SYSTEM MANIFESTATIONS OF ACID SPHINGOMYELINASE DEFICIENCY

Patient Information

Patient name:	Address:
Date of birth:	City: State: Zip:
Gender: □ Male □ Female	Phone (home):
	Phone (work):

Insurance Information

Insurance Co.:	Policy holder name:
Policy ID #:	Insurance phone:
Group #:	

Medical Assessment

Patient weight:________________________(kg/lb) **Patient height:**______________________________(cm/in)

Other:

Applicable Enclosures: □ Patient medical history □ Full prescribing information □ ASM enzyme assay □ *SMPD1* gene sequencing □ Additional supporting clinical documents

Diagnosis

□ **E75.24** □ **E75.240** □ **E75.241** □ **E75.244** □ **E75.248** □ **E75.249** Date of confirmed diagnosis: _____________

How was the diagnosis confirmed? Confirmation requires the presence of #1 OR #2 below.

1.	☐ **ASM enzyme activity** Value:_____________(units) Date:_____________ Normal reference range:_________________________ for laboratory & sample	**Sample type:** ☐ Isolated peripheral blood leukocytes ☐ Cultured skin fibroblasts ☐ Dried blood spots
2.	☐ ***SMPD1* gene sequencing** Date:______________ List pathogenic variants 1.________________________ 2.________________________	**Additional information (if needed):**

Treatment Recommendation

XENPOZYME™ (olipudase alfa-rpcp) **NDC: 58468-0050-1**

Dose:________________________**mg/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 (printed):____Date:______________

Address:_____________________________________City:______________________State:______Zip:_________

Phone:_______________________________________

Physician signature:____

Physician's medical license #:______________________________**State issued:**_____________________________