

Member Name: _____ Member ID: _____ Member DOB: _____
 Drug Name: _____ Strength: _____ Directions: _____
 Physician Name: _____ Physician Phone #: _____ Specialty: _____
 Physician Fax #: _____ Pharmacy Name: _____ Pharmacy Phone: _____

Horizon NJ Health
Medical Necessity Form General

Questions	Answers
1. What is the diagnosis?	
2. Will the patient be receiving this therapy with any other therapy in order to treat this condition? If Yes , what?	Yes No Drug Name: _____ Strength: _____ Qty: _____ Drug Name: _____ Strength: _____ Qty: _____ Drug Name: _____ Strength: _____ Qty: _____
3. Has patient tried any alternative therapy?	Yes No
4. If answer to #3 Yes , ask the following questions: a. What alternatives were tried? b. When were they tried? c. Why were they discontinued? ADD ADDITIONAL DRUGS BELOW (UNDER NOTES)	1. Drug Name: _____ _____ (Note dates tried) _____ (Reason discontinued) 2. Drug Name: _____ _____ (Note dates tried) _____ (Reason discontinued)
5. What is the member's current weight? (Must be taken within the past 30 days)	_____ lbs Date Taken: _____ _____ kg
6. What is the member's current height? (Must be taken within the past 30 days)	_____ ft/in Date Taken: _____ _____ cm

Physician office's signature* _____ Print Name _____

*Form must be completed and signed by physician or licensed representative from the physician's office