Horizon NJ Health

Hemophilia Medications – Medical Necessity Request

1. How many units per dose were requested by the prescriber (units prescribed)? __________________________

2. What is the acceptable variance requested by the prescriber? __________________________

3. How often is this dose to be administered? __________________________

4. Is this a dose increase or the same dose the member has been receiving?
   □ Dose Increase
   a. When was the dose last received? __________________________
   b. What were the units per dose requested by the prescriber? __________________________
   c. What was the acceptable variance requested by the prescriber? __________________________
   d. How often was this dose administered? __________________________
   e. What was the Assay(s) of the lot number(s) that were dispensed by the pharmacy? __________________________
   □ Same Dose

5. What is the reason for the requested dose?
   □ Active hemorrhage (bleed)
   a. What is the severity of the bleed? □ Mild □ Moderate □ Severe
   □ Surgical Procedure
   a. Is the member having major or minor surgery? □ Major □ Minor
   b. Please describe the type of surgical procedure the member will be undergoing. __________________________

   □ Development of Inhibitor (antibody to factor)
   □ Other: __________________________________________

6. What is the member's current weight? _____lbs _____kg

7. What date was the weight taken? ________________

8. What is the NDC of the factor being used by the pharmacy? __________________________

9. What is the Assay(s) of the lot number(s) being dispensed by the pharmacy (the shipped dose)? __________________________

Physician office's signature* ____________________________ Print Name ____________________________

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

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