

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____ Pharmacy Phone: _____

Horizon NJ Health
Non-Formulary Medications – Medical Necessity Request

1. Can a formulary alternative be tried instead?

Yes - Please call a new prescription into the pharmacy for the formulary alternative.

No - Why is it that the patient cannot switch to an alternative? If the member cannot switch due to a contraindication/drug interaction, please specify.

2. What is the member's diagnosis?

3. Please list all alternative tried, the dates tried, and discontinuation reason(s).

Drug Name	Dates Tried	Discontinuation Reason *If due to a side effect or intolerance, please describe.

4. Will the member be taking any other medications concurrently with this drug?

No

Yes – Please list the drugs the member will be taking.

5. Is the patient currently receiving the medication?

No

Yes - How long has the member been on this drug? _____

- When was it last filled? _____

6. What is the member's weight? _____ lbs OR _____ kg

7. What is the member's height? _____ feet/inches OR _____ cm

Physician office's signature* _____ Print Name _____

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