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 for Non-Formulary or Non-Preferred Medications

Questions	Answers
1. Can a formulary alternative be tried instead?	**Yes** **No** **(If YES, please call a new prescription into the pharmacy for the formulary alternative. If NO, continue.)**
2. Why is it that the patient cannot switch to an alternative? If the member cannot switch due to a contraindication/drug interaction, please specify.	
3. What is the patient's diagnosis?	
4. Has patient tried any alternative medications?	**Yes** **No**
5. If answer to **#4 Yes**, ask the following questions: a. What alternatives were tried? b. When were they tried? c. For how long did the member take the alternative(s)? *d.* Why were they discontinued? If due to a side effect or intolerance, please describe.	**1. Drug Name:**_____________________________ _______________________________**(Note dates tried)** _______________________________**(How long on the drug?)** _______________________________**(Reason discontinued)** **2. Drug Name:**_____________________________ _______________________________**(Note dates tried)** _______________________________**(How long on the drug?)** _______________________________**(Reason discontinued)**
6. Will the member be taking any other medications concurrently with this drug? If so, please list the drugs the member will be taking.	**Yes** **No** **Drug Name(s):**____
7. Is the patient currently receiving the medication?	**Yes** **No**
8. How long has patient been on this drug?	
9. When was the medication last filled?	

Physician office's signature*_________________________________ **Print Name**________________________________

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