

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

Drug Name: _____ Strength: _____ Directions: _____

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

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

Horizon NJ Health
Admelog Solostar – Medical Necessity Request

General Questions:

1. What are the specific directions for use? _____

2. Has the member tried Admelog Vials?

Yes: Why were Admelog Vials discontinued?

Dates tried: _____

No: Would the prescriber consider prescribing Admelog Vials?

Yes: Please call the prescription for Admelog Vials in to the pharmacy

No: Please provide clinical reasoning why Admelog Vials cannot be tried.

Physician office's signature* _____ Print Name _____

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