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

Drug Name: _____ Strength: _____ Directions: _____

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

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

Horizon NJ Health

Methadone – Medical Necessity Request

Please indicate if the member has any of the following contraindications:

□ Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment

□ Has known or is suspected of having gastrointestinal obstruction including paralytic ileus

□ Significant respiratory depression

□ NONE

What is the diagnosis?

□ Pain

a. What is the severity of the member's pain?

□ Mild

□ Moderate

□ Severe

b. Can the member try an alternative treatment(s) (e.g., non-opioid analgesics or immediate-release opioids) instead?

□ Yes - Please call the medication prescription to the member's pharmacy

□ No - Please provide clinical reason why

_____

_____

□ Opioid withdrawal/Opioid dependence

□ Other: _____

Physician office's signature*_____ Print Name_____

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

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

Drug Name: _____ Strength: _____ Directions: _____

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

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

****Complete page 2 only for Subsequent/Renewal requests****

1. What is the diagnosis?
   - □ Pain
     - What is the severity of the member's pain? □ Mild □ Moderate □ Severe
   - □ Opioid Withdrawal/Opioid dependence
   - □ Other: _____
2. What was the previous dose? _____
3. Will the previous dose be discontinued?
   - □ Yes □ No- will be taking in addition to new dose □ No- Same as previous dose
4. If the dosage is being increased, how long was the member on the previous dose for? _____

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**