Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: ______________________________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: ______________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

Horizon NJ Health

Brand Name Medically Necessary – Medical Necessity Request

*****Complete page 1 for Initial Requests Only*****

1. What is the diagnosis? ____

2. Has the member tried the generic equivalent product?

   □ **Yes:**

   a. When did the member try the generic (please provide date)? _____________________

   b. Please provide clinical rationale as to why the generic was discontinued. If generic was discontinued due to side effects or allergic reaction, please specify/describe the side effects/allergic reactions the member experienced

   ____
   ____
   ____

   □ **No:**

   a. Please provide the clinical reason why the member has not tried the generic.

   ____
   ____

   b. Can the member be switched to the generic version of the medication?

   □ **Yes:** Please call the pharmacy and notify them of the change.

   □ **No:** Please provide clinical rationale as to why the member cannot try the generic.

   ____
   ____

3. Has the member tried other formulary medications?

   □ **Yes:** Please provide the names of other medications the member has tried and the specific reason why each was discontinued.

   ____
   ____

   □ **No:** Please provide the reason why the member has not tried other formulary medications.

   ____
   ____

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: __________________

Horizon NJ Health

Brand Name Medically Necessary – Medical Necessity Request

*****Complete page 2 for Subsequent/Renewal Requests Only*****

1. What is the diagnosis? ____

Physician office's signature*________________________________ Print Name________________________________

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