Horizon NJ Health

Penicillamine (Cuprimine) and Trientine (Syprine) – Medical Necessity Request

**Complete page 1 for Initial Requests Only**

General Questions:

1. What other medications has the member received for this diagnosis? ______________________________
   
a. How long were the medications tried for (please provide dates)? ______________________________
   
b. Why were they discontinued? ________________________________________________________________
   
Diagnosis Information (please indicate the diagnosis and answer the related questions):

☐ Wilson’s Disease (please send documentation of the member’s diagnosis (e.g. office notes)

☐ Cystinuria (please send documentation of the member’s diagnosis (e.g. office notes)
   1. Has the member tried treatment with conservative measures (e.g. high fluid intake, sodium and protein restriction, urinary alkalization)? Yes or No
      - If no, please let us know the reason why ___________________________________________________
      - If Yes, why was it discontinued? _______________________________________________________

☐ Rheumatoid Arthritis (please send documentation of the member’s diagnosis, severity of the disease and if it is active (e.g. office notes)
   1. What is the severity of the disease? _________________________
   2. Is the disease active? Yes or No
   3. Does the member have a history or other evidence of renal insufficiency? Yes or No
   4. Does the member have any contraindications to any medications such as methotrexate, hydroxychloroquine, leflunomide, sulfasalazine or Depen? Yes or No
      - If yes, please list the name of the drugs and specific contraindication ___________________________
   5. Is the member pregnant, Yes or No

☐ Other _______________________________________________________________________________________

Physician office’s signature* ___________________________ Print Name ___________________________

*Form must be completed and signed by physician or licensed representative from the physician’s office
**Complete page 2 only for Subsequent/Renewal requests**

**Diagnosis Information** (please indicate the diagnosis and answer the related questions):

- Wilson’s disease
- Cystinuria
- Rheumatoid Arthritis

  1. Does the member have the evidence of renal insufficiency? **Yes or No**

  2. Is the member pregnant? **Yes or No**

- Other _______________________________________________________________________

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