Nitroglycerin Ointment (Rectiv®) – Medical Necessity Request
**Complete page 1 for Initial Requests Only**

**Contraindication Information:**

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

- Use of Phosphodiesterase Type 5 (PDE5) inhibitors (e.g. sildenafil, vardenafil and tadalafil)
- Severe anemia
- Increased intracranial pressure
- None

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

- Anal Fissure
  - Does the member have pain associated with the anal fissure? **Yes or No**
    - If Yes, please let us know the severity of the member’s pain.
  - How long has the anal fissure been present?
  - How many weeks of therapy has the member received?
  - What is the requested length of therapy?
- 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):

☐ Anal Fissure
- Does the member have pain associated with the anal fissure? **Yes** or **No**
  - If Yes, please let us know the severity of the member’s pain. ______________________________
- Does the member have chronic anal fissure? **Yes** or **No**
- Has the member responded to therapy by reduction in pain? **Yes** or **No**
- How many weeks of therapy has the member received? _____________________________________

☐ Other: _____________________________________________

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