

Member Name: \_\_\_\_\_ Member ID: \_\_\_\_\_ Member DOB: \_\_\_\_\_

Drug Name: \_\_\_\_\_ Strength: \_\_\_\_\_ Directions: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Physician Phone #: \_\_\_\_\_ Specialty: \_\_\_\_\_

Physician Fax #: \_\_\_\_\_ Pharmacy Name: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_

**Horizon NJ Health**  
***Antibiotics – Medical Necessity Request***

**General Questions:**

1. What is the member's current weight? \_\_\_\_\_ lbs or kg      Date taken \_\_\_\_\_

2. What is the member's current height? \_\_\_\_\_ in or cm      Date taken \_\_\_\_\_

3. Duration of therapy requested \_\_\_\_\_

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

1. What is the member's diagnosis? \_\_\_\_\_

2. Does the member have an infection? **Yes** or **No**  
If yes, which bacteria is causing the member's infection \_\_\_\_\_

3. Were the cultures drawn? **Yes** or **No**  
If yes, please fax over the results

4. What is the location of the infection? \_\_\_\_\_

5. What drugs have previously been tried and failed for this indication?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician office's signature\* \_\_\_\_\_ Print Name \_\_\_\_\_

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