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

Drug Name: _____ Strength: _____ Directions: _____

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

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

Horizon NJ Health

Oxymetazoline hydrochloride ophthalmic solution (Upneeq®) – Medical Necessity Request

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

Diagnosis (please indicate the diagnosis)**:**

□ Treatment of acquired blepharoptosis

□ 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: _____

Horizon NJ Health

Oxymetazoline hydrochloride ophthalmic solution (Upneeq®) – Medical Necessity Request

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

Has the member responded to therapy demonstrated by an improvement from baseline?

□ Yes

□ No

□ Other: _____

Physician office's signature*_____ Print Name_____

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