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

Drug Name: _____ Strength: _____ Directions: _____

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

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

Horizon NJ Health

Mannitol (Bronchitol®) – Medical Necessity Request

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

Diagnosis:

1. Please indicate the member's diagnosis:
   □ Cystic Fibrosis (CF)
   □ Other: _____

2. Has the member passed the Bronchitol Tolerance Test? *(please submit documentation)*
   □ **Yes or** □ **No**

3. Will the member use Bronchitol with standard Cystic Fibrosis therapies (e.g., bronchodilators, antibiotics, chest physiotherapy, etc.)?
   □ **Yes or** □ **No**

4. Will a short-acting bronchodilator be used by oral inhalation 5-15 minutes before every dose of Bronchitol?
   □ **Yes or** □ **No**

5. Is the medication prescribed by or in consultation with a pulmonologist or a specialist in the treatment of Cystic Fibrosis?
   □ **Yes or** □ **No**

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

Mannitol (Bronchitol®) – Medical Necessity Request

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

1. Is the medication prescribed by or in consultation with a pulmonologist or a specialist in the treatment of Cystic Fibrosis?

   □ **Yes or** □ **No**

Physician office's signature*_____ Print Name_____

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