Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: _______________________________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: ______________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

Horizon NJ Health

Vuity – Medical Necessity Request

Complete page 1 for Initial Requests Only

1. Does the member have a diagnosis of presbyopia ?
   □ **Yes**
   □ **No** - what is the member's diagnosis? ____

2. Is the medication being prescribed by or in consultation with an ophthalmologist or optometrist? **Yes or No**

3. Has the member tried the use of corrective eyeglasses or contact lenses?
   - □ Yes: Why can the member no longer continue using corrective eyeglasses or contact lenses? ____
   - □ No: Can the member try corrective eyeglasses or contact lenses instead?
     - □ Yes: Please change to corrective eyeglasses or contact lenses
     - □ No: Please provide the reason why:____

4. Will Vuity be prescribed concurrently with any other ophthalmic pilocarpine formulation? **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
Myalept – Medical Necessity Request
****Complete page 2 only for Subsequent/Renewal requests****

1. Is the member responding positively to therapy? **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**