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

Drug Name: _____________________________ Strength: _______________ Directions: ____

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

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

Horizon NJ Health
Zovirax Ointment – Medical Necessity Request

Diagnosis Information (please select diagnosis and provide requested information below the diagnosis):

□ Genital Herpes

a. Is this an initial episode? □ **Yes** or □ **No**

b. Has the member already tried oral antiviral agents (e.g., acyclovir, valacyclovir, famciclovir)?

□**Yes:** Please provide the name of the oral antiviral agent(s) the member has received and the reason it was stopped:

____

□ **No -** Can member try oral antiviral agent first?

□**Yes:** Please call prescription into the member's pharmacy.

□ **No:** Please provide the clinical reason why an oral antiviral agent cannot be tried.

□ Herpes Labialis (Cold Sore). Please note: Zovirax Ointment is not indicated for the treatment of Herpes Labialis.

a. Has the member already tried Abreva? □ **Yes or** □ **No**

- If **No**, would the physician consider prescribing Abreva instead? □ **Yes or** □ **No**
  - If yes, please call prescription for Abreva in to the pharmacy – prior authorization is not needed.
  - If no, why not?____
- If **Yes**, would the physician consider prescribing Denavir? □ **Yes or** □ **No**
  - If yes, please call prescription for Denavir in to the pharmacy – HNJH will enter a prior authorization.
  - If no, why not?____

□ Other: ____

- What is the affected area? ____________________________________

Please also answer the following question:

□ Is the member immunocompromised (e.g., HIV/AIDS, organ transplant)? □ **Yes or** □ **No**

- If yes, please describe the condition or situation that causes the member to be immunocompromised.
  ____
- If yes, is this a life-threatening episode? □ **Yes or** □ **No**
  - If yes, please describe how this is a life-threatening episode:
    ____

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: __________________

Physician office's signature*_______________________________ Print Name______________________________

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