

Member Name: _____ Member ID: _____ Member DOB: _____
 Drug Name: _____ Strength: _____ Directions: _____
 Physician Name: _____ Physician Phone #: _____ Specialty: _____
 Physician Fax #: _____ Pharmacy Name: _____ Pharmacy Phone: _____

Horizon NJ Health
Medical Necessity Form for Daily Dose Exceeded/Increase

Questions	Answers
1. What are the directions for use? (For topicals, please also provide the quantity requested for a 1-month supply)	
2. Please document any other strengths of the SAME medication recently filled including the date filled, quantity, and days supply. (Circle NONE, if none on file.)	Date filled: _____ Prescriber: _____ Strength: _____ Quantity: _____ DS: _____ Date filled: _____ Prescriber: _____ Strength: _____ Quantity: _____ DS: _____ NONE
3. What is the diagnosis?	
4. Is the patient starting at this dose/quantity?	Yes No
5. If answer #5 Yes , why starting at this dose/quantity? If request is for a topical product, please specify the areas of application.	
6. If answer #5 No , please ask the following questions: a. What was the previous dosing regimen? b. How long has the patient been on the previous dosage regimen? c. Why increasing or giving this dose/quantity?	_____ (Previous dosing regimen) _____ _____
7. What is the member's current weight? (Must be taken within the past 30 days)	_____ lbs Date Taken: _____ _____ kg
8. What is the member's current height? (Must be taken within the past 30 days)	_____ ft/in Date Taken: _____ _____ cm

Physician office's signature* _____ Print Name _____

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