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 General

Questions	Answers
1. What is the diagnosis?	
2. Will the patient be receiving this therapy with any other therapy in order to treat this condition? If **Yes**, what?	**Yes** **No** **Drug Name:_____Strength:_____Qty:_____** **Drug Name:_____Strength:_____Qty:_____** **Drug Name:_____Strength:_____Qty:_____**
3. Has patient tried any alternative therapy?	**Yes** **No**
4. If answer to **#3 Yes**, ask the following questions: a. What alternatives were tried? b. When were they tried? c. Why were they discontinued? **ADD ADDITIONAL DRUGS BELOW (UNDER NOTES)**	**1. Drug Name:_____** **_____(Note dates tried)** **_____(Reason discontinued)** **2. Drug Name:_____** **_____(Note dates tried)** **_____(Reason discontinued)**
5. What is the member's current weight? (Must be taken within the past 30 days)	**_____ lbs** **Date Taken: _____** **_____ kg**
6. 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**