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

Drug Name: _____ Strength: _____ Directions: _____

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

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

Horizon NJ Health

Hemophilia Medications – Medical Necessity Request

1. How many units per dose were requested by the prescriber (units prescribed)? _____

2. What is the acceptable variance requested by the prescriber? _____

3. How often is this dose to be administered? _____

4. Is this a dose increase or the same dose the member has been receiving?
   - □ Dose Increase
     - a. When was the dose last received? _____
     - b. What were the units per dose requested by the prescriber? _____
     - c. What was the acceptable variance requested by the prescriber? _____
     - d. How often was this dose administered? _____
     - e. What was the Assay(s) of the lot number(s) that were dispensed by the pharmacy? _____
   - □ Same Dose

5. What is the reason for the requested dose?
   - □ Active hemorrhage (bleed)
     - a. What is the severity of the bleed? □ Mild □Moderate □Severe
   - □ Surgical Procedure
     - a. Is the member having major or minor surgery? □ Major □ Minor
     - b. Please describe the type of surgical procedure the member will be undergoing. _____ _____
   - □ Development of Inhibitor (antibody to factor)
   - □ Other: _____

6. What is the member's current weight? _____lbs _____kg

7. What date was the weight taken? _____

8. What is the NDC of the factor being used by the pharmacy? _____

9. What is the Assay(s) of the lot number(s) being dispensed by the pharmacy (the shipped dose)? _____

Physician office's signature*_____ Print Name_____

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