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

Drug Name: _____ Strength: _____ Directions: _____

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

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

Horizon NJ Health

Non-Formulary Medications – Medical Necessity Request

1. Can a formulary alternative be tried instead?
   □ **Yes** - Please call a new prescription into the pharmacy for the formulary alternative.
   □ **No** - Why is it that the patient cannot switch to an alternative? If the member cannot switch due to a contraindication/drug interaction, please specify.
   _____
   _____
   _____

2. What is the member's diagnosis?
   _____

3. Please list all alternative tried, the dates tried, and discontinuation reason(s).

Drug Name	**Dates Tried**	**Discontinuation Reason** *If due to a side effect or intolerance, please describe.

4. Will the member be taking any other medications concurrently with this drug?
   □ **No**
   □ **Yes –** Please list the drugs the member will be taking.
   _____
   _____

5. Is the patient currently receiving the medication?
   □ **No**
   □ **Yes** - How long has the member been on this drug? _____
   - When was it last filled? _____

6. What is the member's weight? _____ lbs OR _____kg

7. What is the member's height? _____feet/inches OR _____cm

Physician office's signature*_____ Print Name_____

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