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

Drug Name: _____ Strength: _____ Directions: _____

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

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

Horizon NJ Health

Pancreatic Enzymes (Creon, Zenpep, Pancreaze, etc.) – Medical Necessity Request

1. What is the member's diagnosis? _____
2. What is the member's weight? _____lbs _____kg
3. How many meals will the member be eating per day? _____
4. How many snacks will the member be eating per day? _____

Physician office's signature*_____ Print Name_____

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