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

Drug Name: _____ Strength: _____ Directions: _____

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

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

Horizon NJ Health
Pulmonary Hypertension Agents – Medical Necessity Request

Diagnosis Information (please indicate the diagnosis and answer the related questions):

1. What is the member's diagnosis?
   - □ Pulmonary Hypertension
   - □ High altitude pulmonary edema (HAPE)
   - □ Other_____

2. What is the member's weight? _____ lbs
   _____ kg

For High altitude pulmonary edema (HAPE)

1. Is the medication being used for prevention (prophylaxis) or treatment of High attitude pulmonary edema (HAPE)?

   □ Prevention (Prophylaxis) □ Treatment

2. Does member have prior history of High altitude pulmonary edema (HAPE)? **Yes** or **No**

3. Has the member tried other medications in the past for HAPE? **Yes** or **No**

   If Yes:

   What other medications has the member received in past for High altitude pulmonary edema (HAPE)?

   _____

   Why were the previous medication(s) discontinued?

   _____

   If No, Please provide reason why not? _____

Physician office's signature*_____ Print Name_____

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

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

Drug Name: _____ Strength: _____ Directions: _____

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

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

Complete page 2 only for Subsequent/Renewal requests

1. What is the member's diagnosis?
   - □ Pulmonary Hypertension
   - □ High altitude pulmonary edema (HAPE)
   - □ Other_____

2. What is the member's weight? _____ lbs
   _____ kg

For High altitude pulmonary edema (HAPE)

Is the medication being used for prevention (prophylaxis) or treatment of High altitude pulmonary edema (HAPE)?

□ Prevention (Prophylaxis) □ Treatment

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**