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

Drug Name: _____ Strength: _____ Directions: _____

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

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

Horizon NJ Health

Vaccines – Medical Necessity Request

1. Is the vaccine for a routine vaccination or for travel?

□ Routine

- Does the member have any chronic conditions [e.g., Diabetes, Liver Disease, Kidney Disease, Asplenia (does not have a spleen), HIV/AIDS]? **Yes or No**
  - If Yes, please list the specific condition(s):

    _____
- Is this a booster or catch-up vaccination? **Yes or No**
  - If yes,please provide number of doses being requested_____
- How many doses in the schedule or series has the member received in the past?

  _____
- What dates did the member receive the previous doses?

  _____
- What is the vaccine being prescribed for?

  □ Job Requirement

  - What is the member's occupation? _____

  □ School/College

  - Will the member be living in a dormitory? **Yes or No**
  - If applicable, please document if the member will be working/studying in an environment/facility that would require vaccination (e.g., healthcare, laboratory with Hepatitis A infected primates, day-care)

    _____

  □ Other: _____

□ Travel

- Where is the member traveling to? (provide specific country): _____
- What is the purpose of this visit? _____

<u>Please complete the following questions for members less than 19 years of age:</u>

1. Does the prescriber's office participate in the Vaccines for Children (VFC) Program? **Yes or No**
   - If <u>Yes,</u> is the vaccine covered under the VFC program? **Yes or No** (Please refer to http://www.cdc.gov/vaccines/programs/vfc/awardees/vaccine-management/price-list/index.html)
     - If covered, can the vaccine be ordered through the VFC? **Yes or No**
       - If no, why not?

     _____

     _____
   - If <u>No</u>, please provide the reason why the office does not participate in the VFC*:

     _____

** Note: Offices may enroll in the NJ VFC program via phone at 609-826-4862.*

Physician office's signature*_____ Print Name_____

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