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

Drug Name: _____ Strength: _____ Directions: _____

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

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

Horizon NJ Health

Brand Name Medically Necessary – Medical Necessity Request

*****Complete page 1 for Initial Requests Only*****

1. What is the diagnosis? _____

2. Has the member tried the generic equivalent product?

□ **Yes:**

a. When did the member try the generic (please provide date)? _____

b. Please provide clinical rationale as to why the generic was discontinued. If generic was discontinued due to side effects or allergic reaction, please specify/describe the side effects/allergic reactions the member experienced

_____

_____

_____

□ **No:**

a. Please provide the clinical reason why the member has not tried the generic.

_____

_____

b. Can the member be switched to the generic version of the medication?

□ **Yes:** Please call the pharmacy and notify them of the change.

□ **No:** Please provide clinical rationale as to why the member cannot try the generic.

_____

_____

3. Has the member tried other formulary medications?

□ **Yes:** Please provide the names of other medications the member has tried and the specific reason why each was discontinued.

_____

_____

□ **No:** Please provide the reason why the member has not tried other formulary medications.

_____

_____

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: _____

Horizon NJ Health

Brand Name Medically Necessary – Medical Necessity Request

*****Complete page 2 for Subsequent/Renewal Requests Only*****

1. What is the diagnosis? _____

Physician office's signature*_____ Print Name_____

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