Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: ______________________________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: ____________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

Horizon NJ Health

Penicillamine (Cuprimine) and Trientine (Syprine) – Medical Necessity Request

General Questions:

1. What other medications has the member received for this diagnosis? ___________________________________
   a. How long were the medications tried for (please provide dates)? ___________________________________
   b. Why were they discontinued? ____

- ______________________________________

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

□ Wilson's Disease (please send documentation of the member's diagnosis (e.g. office notes)

□ Cystinuria (please send documentation of the member's diagnosis (e.g. office notes)

1. Has the member tried treatment with conservative measures (e.g. high fluid intake, sodium and protein restriction, urinary alkalinization)? **Yes or No**
   -If no, please let us know the reason why ____
   - If yes, why was it discontinued? ____

□ Rheumatoid Arthritis (please send documentation of the member's diagnosis, severity of the disease and if it is active (e.g. office notes)

1. What is the severity of the disease? ___________________________
2. Is the disease active? **Yes or No**
3. Does the member have a history or other evidence of renal insufficiency? **Yes or No**
4. Does the member have any contraindications to any medications such as methotrexate, hydroxychloroquine, leflunomide, sulfasalazine or Depen? **Yes or No**
   -If yes, please list the name of the drugs and specific contraindication ______________________________________
5. Is the member pregnant? **Yes or No**

□ Other ____

Physician office's signature*_________________________________ Print Name________________________________

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