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

Drug Name: _____ Strength: _____ Directions: _____

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

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

Horizon NJ Health

Admelog Solostar – Medical Necessity Request

General Questions:

1. What are the specific directions for use? _____

2. What is the diagnosis? _____

3. Has the member tried Admelog Vials?

☐ **Yes**: Why were Admelog Vials discontinued?

_____

_____

☐ **No**: Would the prescriber consider prescribing Admelog Vials?

☐ Yes: Please call the prescription for Admelog Vials in to the pharmacy

☐ No: Please provide clinical reasoning why Admelog Vials cannot be tried.

_____

_____

_____

Physician office's signature*_____ Print Name_____

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