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

Drug Name: _____ Strength: _____ Directions: _____

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

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

Horizon NJ Health

Nitroglycerin Ointment (Rectiv®) – Medical Necessity Request

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

Contraindication Information:

Please indicate if the member has any of the following contraindications to therapy:

□ Use of Phosphodiesterase Type 5 (PDE5) inhibitors (e.g. sildenafil, vardenafil and tadalafil)
□ Severe anemia
□ Increased intracranial pressure
□ None

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

□ Anal Fissure
- Does the member have pain associated with the anal fissure? **Yes or No**
  - If Yes, please let us know the severity of the member's pain. _____
- How long has the anal fissure been present? _____
- How many weeks of therapy has the member received? _____
- What is the requested length of therapy? _____

□ Other: _____

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****

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

□ Anal Fissure

- Does the member have pain associated with the anal fissure? **Yes or No**
  - If Yes, please let us know the severity of the member's pain. _____
- Does the member have chronic anal fissure? **Yes or No**
- Has the member responded to therapy by reduction in pain? **Yes or No**
- How many weeks of therapy has the member received? _____

□ Other: _____

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