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

Drug Name: _____ Strength: _____ Directions: _____

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

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

Horizon NJ Health

Antibiotics – Medical Necessity Request

General Questions:

1. What is the member's current weight? _____ lbs or kg Date taken _____

2. What is the member's current height? ___ _____ in or cm Date taken _____

3. Duration of therapy requested _____

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

1. What is the member's diagnosis? _____

2. Does the member have an infection? **Yes** or **No**
   If yes, which bacteria is causing the member's infection _____

3. Were the cultures drawn? **Yes** or **No**
   If yes, please fax over the results

4. What is the location of the infection? _____

5. What drugs have previously been tried and failed for this indication?
_____
_____
_____

Physician office's signature*_____ Print Name_____

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