Pharmacy Prior Authorization Exception Form

Please complete this form, or ask your doctor to complete this form on your behalf, to request an exception.

Your name: ______________________________

Member ID number: ______________________________

Member name: ______________________________

Member date of birth: ______________________________

Member phone number: ______________________________

Drug name: ______________________________

Prescriber name: ______________________________

Prescriber phone number: ______________________________

Pharmacy name: ______________________________

Pharmacy phone number: ______________________________

Reason for needing the requested drug: ______________________________

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Please mail your completed form to: **Horizon NJ Health**
1700 American Blvd.
Pennington, NJ 08534
Mailstop: HL-01P

Or fax to: **1-888-567-0681**

If you have any questions, please call the Horizon NJ Health Pharmacy Department at **1-800-682-9094 x81016** (TTY **711**), weekdays, 8 a.m. to 6 p.m., and Saturday, 8 a.m. to 4:30 p.m., Eastern Time.

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