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

Drug Name: _____ Strength: _____ Directions: _____

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

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

Horizon NJ Health

Metformin Step Therapy – Medical Necessity Request

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

1. What is the member's diagnosis?

   ☐ Type II Diabetes

   ☐ Other: _____

2. What drug is being requested? _____

3. Is the member currently taking the requested medication? **Yes or No**

4. Has the member tried metformin?

   ☐ **Yes**: How long did the member try metformin (please provide dates)? _____

   _____

   Why was metformin discontinued (for allergic reaction or intolerance to metformin, please provide the specific reason)?

   _____

   _____

   ☐ **No**: Would the prescriber consider prescribing metformin?

   ☐ Yes: Please call the prescription for metformin in to the pharmacy

   ☐ No: Please provide clinical reasoning why metformin 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**