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

Drug Name: _____ Strength: _____ Directions: _____

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

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

Horizon NJ Health
Medical Necessity Form for Daily Dose Exceeded/Increase

Questions	Answers
1. What are the directions for use? (For topicals, please also provide the quantity requested for a 1-month supply)	
2. Please document any other strengths of the SAME medication recently filled including the date filled, quantity, and days supply. (Circle NONE, if none on file.)	**Date filled:_____Prescriber:_____** **Strength:_____Quantity:_____DS:_____** **Date filled:_____Prescriber:_____** **Strength:_____Quantity:_____DS:_____** **NONE**
3. What is the diagnosis?	
4. Is the patient starting at this dose/quantity?	**Yes** **No**
5. If answer **#5 Yes**, why starting at this dose/quantity? If request is for a topical product, please specify the areas of application.	
6. If answer **#5 No**, please ask the following questions: a. What was the previous dosing regimen? b. How long has the patient been on the previous dosage regimen? c. Why increasing or giving this dose/quantity?	**_____(Previous dosing regimen)** **_____** **_____**
7. What is the member's current weight? (Must be taken within the past 30 days)	**_____ lbs** **Date Taken: _____** **_____ kg**
8. What is the member's current height? (Must be taken within the past 30 days)	**_____ft/in** **Date Taken: _____** **_____cm**

Physician office's signature*_____ Print Name_____

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