

Member Name: _____ Member ID: _____ Member DOB: _____
Drug Name: _____ Strength: _____ Directions: _____
Physician Name: _____ Physician Phone #: _____ Specialty: _____
Physician Fax #: _____ Pharmacy Name: _____ Pharmacy Phone: _____

Horizon NJ Health
Pulmonary Hypertension Agents – Medical Necessity Request

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

1. What is the member's diagnosis?
 Pulmonary Hypertension
 High altitude pulmonary edema (HAPE)
 Other _____

2. What is the member's weight? _____ lbs
_____ kg

For pulmonary Hypertension:

Is the member managed by Pulmonologist or/and Cardiologist? **Yes** or **No**

For High altitude pulmonary edema (HAPE)

Is the medication being used for prevention (prophylaxis) or treatment of High altitude pulmonary edema (HAPE)?

- Prevention (Prophylaxis) Treatment

Does member have prior history of High altitude pulmonary edema (HAPE)? **Yes** or **No**

Is the member managed by a Pulmonologist? **Yes** or **No** Has the member tried other medications in the past for HAPE? **Yes** or **No**

If Yes:

What other medications has the member received in past for High altitude pulmonary edema (HAPE)?

Why were the previous medication(s) discontinued?

If No, Please provide reason why not? _____

Physician office's signature* _____ Print Name _____

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

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****Complete page 2 only for Subsequent/Renewal requests****

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- Pulmonary Hypertension
- High altitude pulmonary edema (HAPE)
- Other _____

2. What is the member's weight? _____ lbs
_____ kg

For High altitude pulmonary edema (HAPE)

Is the medication being used for prevention (prophylaxis) or treatment of High altitude pulmonary edema (HAPE)?

- Prevention (Prophylaxis)
- Treatment

Physician office's signature* _____ Print Name _____

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