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

Drug Name: _____ Strength: _____ Directions: _____

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

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

**Horizon NJ Health**

***U-500 Insulin Products – Medical Necessity Request***

1. What type of insulin syringe will be used with this product?
   - □ U-100 Insulin Syringe (100units/ml)
   - □ Tuberculin Syringe (500 units/ml)
   - □ Other: _____

2. Are the directions (the number of units per dose) given in the units of U-500 insulin or the units as measured on a U-100 Insulin Syringe?
   - □ U-500 Insulin
   - □ U-100 Syringe

**Physician office's signature*_____ Print Name_____**

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