

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

Horizon NJ Health
Penicillamine (Cuprimine) and Trientine (Syprine) – Medical Necessity Request
*****Complete page 1 for Initial Requests Only*****

General Questions:

1. What other medications has the member received for this diagnosis? _____
 - a. How long were the medications tried for (please provide dates)? _____
 - b. Why were they discontinued? _____
- _____

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

- Wilson's Disease (please send documentation of the member's diagnosis (e.g. office notes))
- Cystinuria (please send documentation of the member's diagnosis (e.g. office notes))
1. Has the member tried treatment with conservative measures (e.g. high fluid intake, sodium and protein restriction, urinary alkalinization)? **Yes or No**
-If no, please let us know the reason why _____
- If Yes, why was it discontinued? _____
- Rheumatoid Arthritis (please send documentation of the member's diagnosis, severity of the disease and if it is active (e.g. office notes))
1. What is the severity of the disease? _____
 2. Is the disease active? **Yes or No**
 3. Does the member have a history or other evidence of renal insufficiency? **Yes or No**
 4. Does the member have any contraindications to any medications such as methotrexate, hydroxychloroquine, leflunomide, sulfasalazine or Depen? **Yes or No**
-If yes, please list the name of the drugs and specific contraindication _____
 5. Is the member pregnant,? **Yes or No**
- Other _____

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

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

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

Wilson's disease

Cystinuria

Rheumatoid Arthritis

1. Does the member have the evidence of renal insufficiency? **Yes or No**

2. Is the member pregnant? **Yes or No**

Other _____

Physician office's signature* _____ Print Name _____

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