NJM Insurance Group

NEW JERSEY MANUFACTURERS INSURANCE COMPANY
301 Sullivan Way, West Trenton, NJ 08628
609-883-1300 / www.NJM.com

LETTER OF MEDICAL NECESSITY

Date:

Prescriber Name: _____
Address City, State, ZIP: _____
Phone: _____
Fax: _____

Claimant's Name: _____
Claim Number: _____
Date of Injury: _____

Dear Prescriber:

The medication(s) _____ you prescribed for this patient is/are not included in the NJM/ODG (Official Disability Guidelines) Formulary as a preferred medication. To determine the medical necessity for the medication(s) for your patient's work-related injury, **please fill out the below information and attach all medical based evidence to support your request, which should include a summary of all past medications trialed prior to this request.**

Patient's diagnosis _____

Detail the medical based evidence to support use of the requested medication.

_____

_____

List medications trialed prior to this medication request:

_____

_____

Goals for use of this medication, duration and anticipated outcome:

_____

_____

Please sign and return this form to the RN Pharmacy Precertification Department by fax at **609-671-4830** or email to RNPharmacyReview@njm.com. We will return our determination of medical necessity approval or denial via fax within two (2) business days of NJM's receipt of all the above requested information. If you have any questions, you can reach our clinical team at **609-883-1300, ext. 6210.**

Physician Signature _____ Date _____

Please refer to the Pharmacy Benefits Information at
njm.com/insurance/business/workers-compensation/pharmacy-benefit for additional information
or contact the Pharmacy Precertification Department at **609-883-1300, ext. 6210**.