Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: ______________________________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: _______________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

Horizon NJ Health
Imiquimod (Aldara) – Medical Necessity Request

Complete pages 1 and 2 for New/Initial Requests

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

☐ Actinic Keratosis (Solar Keratosis)

a. Is surgery and radiation contraindicated or medically less appropriate? **Yes or No**
b. Has the member received therapy in the past for the same area? **Yes** or **No**
c. If Yes, how many weeks of therapy has the member received? ____________________
d. Where is the affected area? ____
e. Is the member immunocompetent? **Yes or No**

☐ Condyloma Acuminata (i.e. Genital or perianal warts)

a. Are the warts located externally? **Yes or No**
b. Has the member received therapy in the past for the same area? **Yes** or **No**
c. If Yes, how many weeks of therapy has the member received? ____________________
d. Where is the affected area? ____

☐ Herpes Simplex Virus (HSV)

a. Has member failed therapy with Acyclovir, Valacyclovir or Famciclovir? **Yes or No**
b. Is member HIV positive? **Yes or No**

☐ Kaposi Sarcoma

a. Does the member have one of the following:

- □ Limited cutaneous disease that is either symptomatic and/or cosmetically unacceptable
- □ Classic
- □ Transplant-associated
- □ Other: ____

☐ Melanoma

a. Is the melanoma recurrent, in situ (in the original position or place) or neither?
   - ❑ Recurrent
     - Does member have local, satellite and/or in-transit recurrence? **Yes or No**
     - Has diagnosis been confirmed by FNA (Fine needle aspiration) or biopsy? **Yes or No**
     - Is clinical trial an option? **Yes or No**
     - Does the member have superficial dermal lesions (very low volume cutaneous metastases)? **Yes or No**
   - ❑ In situ (including Lentigo Maligna, also known as Hutchinson melanotic freckle)
     - Did the member have positive margins after optimal surgery? **Yes or No**
   - ❑ Neither
     - Does member have stage III, in-transit or locally metastatic melanoma? **Yes or No**
     - Has diagnosis been confirmed by FNA (Fine needle aspiration) or biopsy? **Yes or No**
     - Is clinical trial an option? **Yes or No**
     - Does the member have superficial dermal lesions (very low volume cutaneous metastases)? **Yes or No**

☐ Molluscum contagiosum

Continued on p. 2

Physician office's signature*________________________________ **Print Name**________________________________
***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: ______________________________ Strength: _______________ Directions: _______________________________________

Physician Name: ___________________________ Physician Phone #: _________________________ Specialty: ______________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

☐ Mycosis Fungoides (MF) or Sezary Syndrome (SS)

a. Is the disease regional or localized (limited/localized skin involvement)? **Yes or No**
b. Is disease stage 1A (T1, N0, M0, B0, 1)? **Yes or No**

☐ Penile Cancer

a. Does the member have one of the following:
   - □ Wart-like (Ta) carcinoma
   - □ Carcinoma in situ (Tis)
   - □ None

☐ Primary Cutaneous Marginal Zone Lymphoma (PC-MZL) or Primary Cutaneous Follicle Center Cell Lymphoma (PC-FCL)

a. Please indicate if the member has one of the following:
   - □ Solitary lesions (T1)
   - □ Regional disease (T2)
   - □ Generalized skin lesions (T3)
   - □ Other:____

☐ Squamous cell carcinoma in suit (Bowen's Disease)

a. Is surgery or radiation contraindicated or medically less appropriate?

☐ Superficial Basal Cell Carcinoma

a. Is the cancer low risk? **Yes or No**
   - If yes, are surgery and radiation contraindicated or medically less appropriate? **Yes or No**
b. Is it primary? **Yes or No**
c. Is the carcinoma confirmed by biopsy? **Yes or No**
d. What is the maximum tumor diameter (Please include units (i.e. cm, mm) _______________
e. Where is the tumor located?____
f. Are surgical methods appropriate? **Yes or No**
g. Will there be patient follow up? **Yes or No**
h. Is the member immunocompetent? **Yes or No**

☐ Warts

a. Where are the warts located? ____________________________________
b. Are the warts located externally? **Yes or No**
c. Has the member received therapy in the past for the same area? **Yes** or **No**
   If Yes, How many weeks of therapy has the member received? ____________________
d. Where is the affected area? ____

☐ Other: ____

Physician office's signature*________________________________ Print Name________________________________
***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: ______________________________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: ______________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________ Pharmacy Phone: __________________

Horizon NJ Health
Imiquimod (Aldara) – Medical Necessity Request

****Complete page 3 only for Subsequent/Renewal requests****

1. Has member shown response to therapy or had clinical improvement? **Yes or No**

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

☐ Melanoma
 a. Does the member have one of the following types:
 ☐ In situ, including Lentigo maligna
 ☐ Stage 3 Melanoma

☐ Molluscum contagiosum

☐ Mycosis Fungoides (MF) or Sezary Syndrome (SS)
 a. Is the disease regional or localized? **Yes or No**

☐ Primary Cutaneous Marginal Zone Lymphoma (PC-MZL) or Primary Cutaneous Follicle Center Cell Lymphoma (PC-FCL)
 a. Please indicate which of the following the member has:
 ☐ Solitary lesions (T1)
 ☐ Regional disease (T2)
 ☐ Generalized skin lesions (T3)
 ☐ Other:____

☐ Squamous cell carcinoma in suit (Bowen's Disease)

Physician office's signature*________________________________ Print Name________________________________
***Form must be completed and signed by physician or licensed representative from the physician's office**