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

Drug Name: _____ Strength: _____ Directions: _____

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

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

Horizon NJ Health
– Medical Necessity Request
****Complete page 1-3 for Initial Requests Only****

General Questions:

1. What specialty is managing the member? _____
2. What is the member's weight? _____lbs or _____ kg

Safety/Contraindication Information:

1. Will the member be concurrently receiving this medication with any other Biologic Disease Modifying Antirheumatic Drug (DMARD) or another Targeted Immune Modulator for the same diagnosis? **Yes or No**
   - If yes, Please give the drug name and the reason for receiving more than one biologic DMARD or Targeted Immune Modulator
   _____

3. For Kineret requests, does the member have known hypersensitivity to E coli-derived proteins? **Yes or No**

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

□ Cryopyrin-Associated Periodic Syndromes (CAPS)
   1. Does the member have one of the following?
      □ Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Auto-inflammatory syndrome (FCAS) and Muckle-Wells Syndrome (MWS)
      □ Cryopyrin-Associated Periodic Syndromes (CAPS) including Neonatal-Onset Multisystem Inflammatory Disease (NOMID) also known as chronic infantile neurologic cutaneous articular syndrome (CINCA)
      □ Other, please specify: _____
   2. Is the medication prescribed by or in consultation with a rheumatologist or physician experienced in the treatment of genetic disorders? **Yes or No**

□ Deficiency of interleukin-1 receptor antagonist (DIRA)
   For Kineret Requests please answer questions 1-2
   1. Will the member be using Kineret for the treatment of deficiency of interleukin-1 receptor antagonist? **Yes or No**
   2. Is the medication prescribed by or in consultation with a physician experienced in the treatment of genetic disorders? **Yes or No**

   For Arcalyst Requests please answer questions 3-4
   3. Will the member be using Arcalyst for the maintenance of remission of deficiency of interleukin-1 receptor antagonist? **Yes or No**
   4. Is the medication prescribed by or in consultation with a physician experienced in the treatment of genetic disorders? **Yes or No**

□ Familial Mediterranean Fever (FMF)
   1. Is the member 4 years of age or older? **Yes or No**
      - If yes, has the member tried colchicine? **Yes or No**
         - If yes, why was colcichine stopped?_____
         - If no, is the member able to try colchicine instead? **Yes or No**
            a. If **Yes,** please notify the pharmacy of the change.

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: _____

b. If **No**, please let us know the reason why.

_____

2. Is the medication prescribed by or in consultation with a rheumatologist or physician experienced in the treatment of genetic disorders? **Yes or No**

□ Hidradenitis Suppurativa (HS)

1. What is the severity of the disease (e.g., mild, moderate, severe)? _____
2. Is the medication prescribed by or in consultation with a dermatologist ? **Yes or No**

□ Hyper-immunoglobulin D syndrome (HIDS)/Mevalonate kinase deficiency (MKD)

- Is the medication prescribed by or in consultation with a rheumatologist or physician experienced in the treatment of genetic disorders? **Yes or No**

Continued on p.2

□ Recurrent Pericarditis (RP)

1. Is the medication prescribed by or in consultation with a cardiologist? **Yes or No**
2. Will the member be using Arcalyst for the treatment of recurrent pericarditis? **Yes or No**
3. Is the member 12 years of age or older? **Yes or No**
4. Has the member had an inadequate response to a nonsteroidal anti-inflammatory drugs (NSAIDs), colchicine, and/or oral glucocorticoids for the treatment of recurrent pericarditis? **Yes or No**
   a. **If Yes,** please provide what therapies the member has tried and had an inadequate response to. _____
   b. **If No,** Can the member try a nonsteroidal anti-inflammatory drugs (NSAIDs), colchicine, and/or oral glucocorticoids instead? **Yes or No**
      i. **If Yes,** please notify the pharmacy of the change and return the form.
      ii. **If No,** please provide the reason why.

_____

□ Rheumatoid Arthritis (RA)

1. What is the severity of the disease (e.g., mild, moderate, severe)? _____
2. What other medications/treatments has the member received in the past for this diagnosis?

_____

3. How long was each medications/treatments tried for (please provide dates)?

_____

4. Why were the previous medications discontinued, if applicable?

_____

5. Does the member have any contraindications to any disease modifying antirheumatic drugs (DMARDs) such as: Hydroxychloroquine, Leflunomide, Methotrexate, or Sulfasalazine? **Yes or No**
   a. If yes, please list the name of the drug(s) and the specific contraindication

_____

6. Is the medication prescribed by or in consultation with a rheumatologist or physician experienced in the treatment of genetic disorders? **Yes or No**

□ Schnitzler syndrome

- Is the medication prescribed by or in consultation with a rheumatologist, dermatologist, or immunologist? **Yes or No**

□ Systemic Juvenile Idiopathic Arthritis (sJIA)

- For Kineret Requests please answer questions 1-3:

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: _____

1. Does the member have active systemic features?
   - □ **Yes** (sJIA with active systemic features)
     a. What other medications/treatments has the member received in the past for this diagnosis?_____

     b. Why was each previous medications discontinued, if applicable?
     _____

     c. Does the member have any contraindications to systemic corticosteroids or NSAIDs? **Yes or No**
        - If yes, please list the name of the drug(s) and the specific contraindication
        _____

   - □ **No** (sJIA without active systemic features)
     a. What other medications/treatments has the member received in the past for this diagnosis?
     _____

     b. Why was each previous medications discontinued, if applicable?
     _____

     c. Does the member have any contraindications to methotrexate, leflunomide, non-steroidal anti-inflammatory drugs (NSAIDS), or intra-articular glucocorticosteroids? **Yes or No**
        - If yes, please list the name of the drug(s) and the specific contraindication
        _____

2. Does the member have macrophage activation syndrome (MAS)? **Yes or No**

3. Is the medication prescribed by or in consultation with a rheumatologist or physician experienced in the treatment of genetic disorders? **Yes or No**

Continued on p. 3

- **For Ilaris Requests for sJIA** please answer questions 1-3:

1. Is the disease active? **Yes or No**

2. Does the member have active SYSTEMIC features?
   - □ **Yes** (sJIA with active systemic features)
     a. What other medications/treatments has the member received in the past for this diagnosis?
     _____

     b. Why was each previous medications discontinued, if applicable?
     _____

     c. Does the member have any contraindications to systemic corticosteroids or non-steroidal anti-inflammatory drugs (NSAIDS) or methotrexate or leflunomide or anakinra (Kineret®) or tocilizumab (Actemra®)? **Yes or No**
     - If yes, please list the name of the drug(s) and the specific contraindication
     _____

   - □ **No** (sJIA without active systemic features)
     a. What other medications/treatments has the member received in the past for this diagnosis?
     _____

Physician office's signature*_____ Print Name_____
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Member Name: _____ Member ID: _____ Member DOB: _____

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

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

b. Why was each previous medications discontinued, if applicable?
_____

c. Does the member have any contraindications to DMARD (i.e., methotrexate or leflunomide), anakinra, tocilizumab, TNF-α inhibitor (e.g., adalimumab, etanercept, infliximab), or abatacept ? **Yes or No**
   - If yes, please list the name of the drug(s) and the specific contraindication:
     _____

3. Is the medication prescribed by or in consultation with a rheumatologist or physician experienced in the treatment of genetic disorders? **Yes or No**

□ Tumor necrosis factor receptor associated periodic syndrome (TRAPS)
- Is the medication prescribed by or in consultation with a rheumatologist or physician experienced in the treatment of genetic disorders? **Yes or No**

□ Other _____

Horizon NJ Health
– Medical Necessity Request
****Complete page 4 only for Subsequent/Renewal requests****

1. What is the diagnosis? _____
2. Does the member have documentation of positive clinical response to medication from baseline? **Yes or No**
3. For dose increase requests, please provide the member's weight _____lbs or _____ kg

Physician office's signature*_____ Print Name_____
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Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

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

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

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