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

Drug Name: _____ Strength: _____ Directions: _____

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

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

Horizon NJ Health
Targeted Immune Modulators (TIMs) – Medical Necessity Request
Complete pages 1-3 only for New/Initial requests

General Questions:

1. What is the diagnosis? _____
2. What is the severity of the disease? _____
3. Is the disease active? **Yes or No**
4. Is the disease chronic? **Yes or No**
5. For plaque psoriasis, please answer the following questions:
   a. Was the initial prescription written by or in consultation with a Dermatologist? **Yes or No**
   b. What percentage of body surface area is involved? _____
   c. Please specify the affected areas: _____
   d. Has the member been tested for tuberculosis (TB) prior to the initiation of therapy? (Note, does not apply to Otezla) **Yes or No**
6. For atopic dermatitis, please answer the following questions:
   a. Was the initial prescription written by or in consultation with an Allergist or Dermatologist? **Yes or No**
   b. What percentage of body surface area is involved? _____
   c. Please specify the affected areas: _____
   d. Will success of treatment be assessed regularly? **Yes or No**
7. Does the member have perianal fistula, if applicable? **Yes** or **No**
8. Is the disease is fistulizing, if applicable? **Yes** or **No**
9. Does the member have any other condition(s) associated with the diagnosis?
   _____
10. Is the disease refractory, if applicable? **Yes** or **No**
11. Is the disease life-threatening? **Yes or No**
12. Does the member have inflammation? **Yes or No**
13. Does the member have oral ulcers? Yes or No
14. Does the member have prolonged (>3 days) Grade 1 cytokine release syndrome with significant symptoms and/or comorbidities? Yes or No
15. Is the member requesting medication used for management of Grades 2-4 cytokine release syndrome (CRS)? **Yes or No**
16. How long has the member had cytokine release syndrome (CRS) symptoms?_____
17. Is the member requesting medication used for management neurotoxicity if concurrent cytokine release syndrome (CRS)? **Yes or No**
18. Does the member have any risk factors? **Yes or No**
    - If, yes, please let us know what risk factors the member has._____

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: _____

19. Does the member have involvement of high risk joints (e.g., cervical spine, wrist, or hip)? **Yes or No**
20. Does the prescriber judge the member to be at high risk of disabling joint damage? **Yes or No**
21. Does the member have high disease activity? **Yes or No**
22. Does the member have Castleman's Disease? **Yes or No**

    -If yes, what type of Castleman's Disease does the member have? □ Unicentric □ Multicentric
23. Is the member human immunodeficiency virus-negative? **Yes or No**
24. Is the member human herpesvirus-8-negative?
25. Does the member have severe inflammatory arthritis as an adverse event from cancer chemotherapy? **Yes or No**
26. Is the request related to an Immune-checkpoint inhibitor-related toxicity? **Yes or No**
    If **Yes**, please answer the following questions:
    a. What type of immune-checkpoint inhibitor-related toxicity does the member have?_____
    b. Please list all the specialists this prescription was written in consultation with:_____
    c. If member has uveitis, also answer the following questions:
        i. Does the member have associated vision changes due to immune checkpoint inhibitor related toxicities? **Yes or No**
        ii. Does the member have uvetitis, anterior or intermediate uvetitis (G1 or G2), posterior panuveitis (G3) or 20/200 vision (G4)? **Yes or No**
    d. If the member has diarrhea/colitis, has stool evaluation ruled out infectious cause? **Yes or No**

27. Is the request for graft-versus-host-disease (GVHD)? **Yes or No**
    If **Yes**, please answer the following questions:
    a. Will the member be managed by Immunologist, Oncologist, Transplant specialist, or Infectious Disease Specialist? **Yes or No**
    b. Is this for treatment or prophylaxis? □ Treatment □ Prophylaxis
    c. Has the member had a hematopoietic cell transplant? **Yes or No**
    d. Will the member be undergoing a hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated donor? **Yes or No**
        i. If **Yes**, what is the scheduled date of the transplant?_____

28. Please list all drugs and strengths tried for the diagnosis provided, the dates tried and the discontinuation reasons?

Drug Name and Strength	**Dates Tried**	**Discontinuation Reason**

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: _____

26. Does the member have any contraindications to any medications such as methotrexate, glucocorticoid (steroid) injections, or aminosalicylates (drugs such as mesalamine)? **Yes or No**
    - If so, please list the name of the drug. _____

27. Will the member be taking any other medications concurrently with this medication? **Yes or No**
    - If yes, please list the names of the medications: _____
    _____

28. What is the member's weight? _____lbs or _____ kg

29. What specialty is managing the member? _____

30**. Please provide any other pertinent clinical information regarding the member's diagnosis.**

_____
_____
_____
_____

Safety/Contraindication Information:

1. Will the member be concurrently receiving this medication with another Targeted Immune Modulator? **Yes or No**
    - **If yes**, Please give the drug name and the reason for receiving more than one Targeted Immune Modulator
    _____

Enbrel, Erelzi, Eticovo	**Remicade, Renflexis, Inflectra, Avsola, Ixifi**	**Xeljanz/Xeljanz XR/Olumiant**	**Tysabri**	**Siliq**	**Cibinqo**
□ Known Sepsis □ NONE	□ Moderate to severe heart failure □ NONE	Concurrent use of a □ Biologic Disease Modifying Antirheumatic Drug (DMARD) or □ Immunosuppressant (e.g., azathioprine, tacrolimus, cyclosporine) □ Other Janus kinase (JAK) inhibitors □ NONE	Concurrent use of an □ Immunosuppressant (e.g., azathioprine, tacrolimus, cyclosporine, or methotrexate) or □ TNF-alpha inhibitors (e.g Humira, Enbrel, Remicade, Simponi, Cimzia, etc.) □ Previous or current progressive multifocal leukoencephalopathy (PML) □ NONE	□ Crohn's Disease □ NONE	□ Concurrent use of antiplatelet therapies, except for low-dose aspirin (≤81 mg daily), during the first 3 months of treatment.

Remicade/Renflexis/Inflectra/Avsola/Ixifi requests only:

For diagnoses of Rheumatoid Arthritis, Psoriatic Arthritis, Plaque Psoriasis, Ankylosing Spondylitis, Crohn's Disease, Hidradenitis Suppurativa, Ulcerative Coliti, Immune Checkpoint Inhibitor-related Toxicities :

- Can the member try either Enbrel or Humira, instead? **Yes or No**

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: _____

- If no, please provide the clinical reason why:

_____

- If yes, please call the prescription in to the pharmacy and fill out this form and send to Horizon

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: _____

****Complete page 4 only for Subsequent/Renewal requests****

1. What is the diagnosis? _____
2. What specialty is managing the member ? _____
3. Will the member be taking any other medications concurrently with this medication? **Yes or No**
   - If yes, please list the names of the medications: _____
4. Is the member concurrently receiving this medication with another Targeted Immune Modulator? **Yes or No**
   - If yes, Please give the drug name and the reason for receiving more than Targeted Immune Modulator_____
5. For Xeljanz or Otezla requests: Will the member also be taking a biologic Disease Modifying Antirheumatic Drug (DMARD) or potent immunosuppressant (e.g., azathioprine, tacrolimus, cyclosporine)? **Yes or No**
6. **For the diagnosis of Ulcerative Colitis**: Did the member experienced a decrease compared to baseline? **Yes or No**
   - If **Yes,** the member experienced a decrease in which of the following:
     - □ Number of loose or soft stools
     - □ Frequency of rectal bleeding
     - □ Abdominal pain
     - □ Nocturnal bowel movements
     - □ Urgency
     - □ Fear of episodes of incontinence
     - □ Other: _____

7. For the diagnosis of **Plaque Psoriasis**, please answer the following questions:
   a. Is there documentation of positive clinical response to therapy (less than 3 percent of body surface area [BSA] involvement or 75 percent improvement compared with baseline)? **Yes or No**
   b. Is the member being monitored for active TB during treatment (Note, does not apply to Otezla)? **Yes or No**
   c. Is the member being monitored for lymphoma and other malignancies during treatment (Note, does not apply to Otezla)? **Yes or No**

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