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

Drug Name: _____ Strength: _____ Directions: _____

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

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

Horizon NJ Health

Oncology – Medical Necessity Request

*****Complete Pages 1 and 2 For New/Initial Requests*****

1. What is the member's diagnosis?
   _____
   _____
2. Is the disease advanced? **Yes or No**
3. Is the disease metastatic? **Yes or No**
4. Has the disease progressed on previous therapy? **Yes or No**
5. What other drug(s) or treatment(s) has the member previously received for this diagnosis?
   _____
   _____
6. Will the member be receiving any other drug(s) or treatment(s) with the requested drug? **Yes or No**
   a. If Yes, please provide the name(s) of the drug(s) and/or treatment(s) the member will be receiving:
      _____
      _____
7. Please provide information regarding tumor type, receptor status and/or genetic mutations. (e.g., HER2, estrogen/progesterone, Philadelphia chromosome, RAS, etc.):
   _____
   _____
   _____
   _____
8. How many days are in each chemotherapy cycle? _____
9. Which days in each chemotherapy cycle will the member be receiving the requested drug? _____
10. How many chemotherapy cycles of the requested regimen has the member received in the past?
    _____
11. How many cycles of the requested drug are being requested? _____
12. What stage is the member's cancer? _____
13. What phase of chemotherapy is the member receiving (e.g., induction, consolidation, maintenance, adjuvant, neoadjuvant, etc)? _____
14. Is the cancer recurrent? **Yes or No**

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: _____

15. Has the member previously had surgery for the cancer?
    □ **Yes** – Specify type of surgery:_____
    □ **No** - Is surgery/resection an option for the cancer? _____

16. For members with Breast Cancer, please answer the following questions:
    a. Is the member PR (progesterone receptor) positive or negative? _____
    b. Is the member ER (estrogen receptor) positive or negative? _____
    c. Is the member HER2 positive or negative? _____
    d. Please indicate the member's menopausal status:
       □ pre-menopausal, □ peri-menopausal, or □ post-menopausal
    e. Does the member have high tumor burden? **Yes or No**
    f. Does the member have rapidly progressing disease? **Yes or No**
    g. Does the member have visceral crisis? **Yes or No**

17. Please provide any other pertinent clinical information regarding the member's diagnosis.
    _____
    _____
    _____
    _____
    _____

18. Please provide the member's current weight and height:
    Weight: _____ lbs or _____kg. Date Taken: _____
    Height: _____ inches or _____cm. Date Taken: _____

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 2 for Subsequent/Renewal Requests*

1. What is the member's diagnosis?

_____

_____

_____

2. Has the member shown stabilization of the disease or clinical improvement (i.e. slowing of disease progression or decrease in symptom severity and/or frequency)? **Yes or No**

3. Please provide the member's current weight and height:

Weight: _____ lbs or _____kg. Date Taken: _____

Height: _____ inches or _____cm. Date Taken: _____

Physician office's signature*_____ Print Name_____

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