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 patient immunocompetent? **Yes or No**

☐ Molluscum contagiosum

☐ 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 patient immunocompetent? **Yes or No**
i. Is the disease considered low risk? **Yes or No**
j. Is surgery or radiation not feasible? **Yes or No**

☐ Condyloma Acuminata (i.e. Genital or perianal HPV 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? ______________________________________

☐ 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? ______________________________________

☐ 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**

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: __________________

☐ 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**

☐ Bowen's Disease (squamous cell carcinoma in situ)

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

☐ 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,B 0,1)? **Yes or No**

☐ 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:____

☐ Penile Cancer

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

☐ AIDS-Related Kaposi Sarcoma

a. Does the member have limited cutaneous disease that is either symptomatic and/or cosmetically unacceptable? **Yes or No**

☐ 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

☐ Bowen's Disease (squamos cell carcinoma in situ)

☐ Mycosis Fungoides (MF) or Sezary Syndrome (SS)
- c. 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:____

☐ Penile Cancer

☐ AIDS-Related Kaposi Sarcoma

Physician office's signature*________________________________ Print Name_______________________________

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