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, 2 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. Does the member have perianal fistula, if applicable? **Yes** or **No**
6. Is the disease is fistulizing, if applicable? **Yes** or **No**
7. Does the member have any other condition(s) associated with the diagnosis?
   _____
8. Is the disease refractory, if applicable? **Yes** or **No**
9. Does the member have inflammation? **Yes or No**
10. Does the member have oral ulcers? Yes or No
11. Does the member have prolonged (>3 days) Grade 1 cytokine release syndrome with significant symptoms and/or comorbidities? Yes or No
12. Is the member requesting medication used for management of Grades 2-4 cytokine release syndrome (CRS)? **Yes or No**
13. Is the member requesting medication used for management neurotoxicity as additional single-dose therapy if concurrent cytokine release syndrome (CRS)? **Yes or No**
14. Does the member have any risk factors? **Yes or No**
    - If, yes, please let us know what risk factors the member has._____
15. Does the member have involvement of high risk joints (e.g., cervical spine, wrist, or hip)? **Yes or No**
16. Does the prescriber judge the member to be at high risk of disabling joint damage? **Yes or No**
17. Does the member have high disease activity? **Yes or No**
18. Does the member have Castleman's Disease? **Yes or No**

    -If yes, what type of Castleman's Disease does the member have? □ Unicentric □ Multicentric
19. Is the member human immunodeficiency virus-negative? **Yes or No**
20. Is the member human herpesvirus-8-negative?
21. Does the member have severe inflammatory arthritis as an adverse event from cancer chemotherapy? **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: _____

22. What other medications/treatments and which dosages has the member received in the past for this diagnosis?
_____
_____

23. How long were the medications/treatments tried for (please provide dates)? _____

24. Why were the previous medications discontinued, if applicable?
_____

25. 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. _____

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

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

28. What specialty is managing the member? _____

29. **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**	**Xeljanz/Xeljanz XR/Olumiant**	**Tysabri**	**Siliq**
□ 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

Remicade/Renflexis/Inflectra/Avsola requests only:
For diagnoses of Rheumatoid Arthritis, Psoriatic Arthritis, Plaque Psoriasis, Ankylosing Spondylitis, Crohn's Disease, Hidradenitis Suppurativa, Ulcerative Colitis:
- Can the member try either Enbrel or Humira, instead? **Yes or No**
  - 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 3 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: _____

Physician office's signature*_____ Print Name_____

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