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**

□ 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.
       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

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: _____

□ 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:

1. Does the member have <u>active systemic features</u>?
   - □ **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 <u>without active systemic features</u>)
     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

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: _____

- **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?
        _____

     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 _____

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