**Complete pages 1 and 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 poor prognosis? **Yes** or **No**

6. Is the disease is fistulizing, if applicable? **Yes** or **No**

7. Does the member have any other condition associated with the diagnosis? 
   ______________________________________________________________________

8. Is the disease refractory, if applicable? **Yes** or **No**

9. What other medications/treatments has the member received in the past for this diagnosis? 
   ______________________________________________________________________

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

11. Why were the previous medications discontinued, if applicable? 
    ______________________________________________________________________

12. 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. ______________________________________________________________________

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

14. What is the member’s weight? ______________________ lbs or kg

15. What specialty is managing the member? _________________________________

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

**Continued on p.2**
Safety/Contraindication Information:

1. Will the member be concurrently receiving this medication with another Biological Response Modifier (BRM), Tofacitinib (Xeljanz/Xeljanz XR) or Apremilast (Otezla)? Yes or No
   - If yes, Please give the drug name and the reason for receiving more than one BRM or Xeljanz:

Please indicate if the member has any of the contraindications listed for the requested drug.

<table>
<thead>
<tr>
<th>Enbrel, Erelzi</th>
<th>Remicade, Renflexis, Inflectra</th>
<th>Kineret</th>
<th>Xeljanz/Xeljanz XR</th>
<th>Tysabri</th>
<th>Siliq</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Known Sepsis □ NONE</td>
<td>□ Moderate to severe heart failure □ NONE</td>
<td>□ Known hypersensitivity to E. coli-derived proteins □ NONE</td>
<td>Concurrent use of a □ Biologic Disease Modifying Antirheumatic Drug (DMARD) or □ Immunosuppressant (e.g., azathioprine, tacrolimus, cyclosporine) □ NONE</td>
<td>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</td>
<td>□ Crohn’s Disease □ NONE</td>
</tr>
</tbody>
</table>

Remicade requests only:
For diagnoses of Rheumatoid Arthritis, Psoriatic Arthritis, Plaque Psoriasis, Ankylosing Spondylitis, and Non-Fistulizing Crohn’s Disease:
   - Can the member try either Enbrel or Humira instead of Remicade? Yes or No
     - If no, please provide the clinical reason why the member cannot try either Enbrel or Humira:
     - If yes, please call the prescription in to the pharmacy and fill out this form and send to horizon

16. Please provide any other pertinent clinical information regarding the member’s diagnosis.
**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 Biological Response Modifier (BRM), Tofacitinib (Xeljanz), or Apremilast (Otezla)? **Yes or No**
   - If yes, Please give the drug name and the reason for receiving more than one BRM, Xeljanz or Otezla:
     ________________________________________________________________

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**