Horizon NJ Health

**Biological Response Modifiers (BRM), Janus Kinase Inhibitor, and Apremilast– Medical Necessity Request**

**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. Does the member have perianal fistula, if applicable? Yes or No
7. Is the disease is fistulizing, if applicable? Yes or No
8. Does the member have any other condition associated with the diagnosis? ____________________________
9. Is the disease refractory, if applicable? Yes or No
10. What other medications/treatments has the member received in the past for this diagnosis? ____________________________
11. How long were the medications/treatments tried for (please provide dates)? ____________________________
12. Why were the previous medications discontinued, if applicable? ____________________________
13. 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. ____________________________
14. Will the member be taking any other medications concurrently with this medication? Yes or No
   - If yes, please list the names of the medications: ____________________________
15. What is the member’s weight? ______________ lbs or kg
16. What specialty is managing the member? ____________________________

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

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HNJH Fax #: 888-567-0681
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 Biological Response Modifier (BRM), Janus kinase (JAK) inhibitor 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.

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<th>Enbrel, Erelzi</th>
<th>Remicade, Remflexis, Inflectra</th>
<th>Kineret</th>
<th>Xeljanz/Xeljanz XR/Olumiant</th>
<th>Tysabri</th>
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Remicade/Remflexis/Inflectra 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? 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
**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), Janus kinase (JAK) inhibitor, 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**

6. **For the diagnosis of Ulcerative Colitis**: Did the member experienced a decrease in symptoms? **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: ________________________________________