Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

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**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

17. **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.					
Enbrel, Erelzi	**Remicade, Renflexis, Inflectra**	**Kineret**	**Xeljanz/Xeljanz XR/Olumiant**	**Tysabri**	**Siliq**
□ Known Sepsis □ NONE	□ Moderate to severe heart failure □ NONE	□ Known hypersensitivity to E. coli-derived proteins □ 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 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

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 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: _____

Physician office's signature*_____ Print Name_____

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