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

Drug Name: _____ Strength: _____ Directions: _____

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

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

Horizon NJ Health

Imiquimod (Aldara) – Medical Necessity Request

Complete pages 1 and 2 for New/Initial Requests

Diagnosis Information (please indicate diagnosis and answer related questions):

☐ Actinic Keratosis (Solar Keratosis)

a. Is surgery and radiation contraindicated or medically less appropriate? **Yes or No**
b. Has the member received therapy in the past for the same area? **Yes** or **No**
c. If Yes, how many weeks of therapy has the member received?_____
d. Where is the affected area? _____

☐ Molluscum contagiosum

☐ Vaginal Intraepithelial Neoplasia (VIN)

☐ Superficial Basal Cell Carcinoma

a. Is the cancer low risk? **Yes or No**
   - If yes, are surgery and radiation contraindicated or medically less appropriate? **Yes or No**
b. Is it primary? **Yes or No**
c. Is the carcinoma confirmed by biopsy? **Yes or No**
d. What is the maximum tumor diameter (Please include units (i.e. cm, mm) _____
e. Where is the tumor located?_____
f. Are surgical methods appropriate? **Yes or No**
g. Will there be patient follow up? **Yes or No**
h. Is the patient immunocompetent? **Yes or No**
i. Is the disease considered low risk?
j. Is surgery or radiation contraindicated or medically less appropriate?

☐ Condyloma Acuminata (i.e. Genital or perianal HPV warts)

a. Are the warts located externally? **Yes or No**
b. Has the member received therapy in the past for the same area? **Yes** or **No**
b. If Yes, how many weeks of therapy has the member received?_____
c. Where is the affected area? _____

☐ Warts

a. Where are the warts located? _____
b. Are the warts located externally? **Yes or No**
c. Has the member received therapy in the past for the same area? **Yes** or **No**
   If Yes, How many weeks of therapy has the member received?_____
d. Where is the affected area? _____

☐ Herpes Simplex Virus (HSV)

a. Has member failed therapy with Acyclovir, Valacyclovir or Famciclovir? **Yes or No**
b. Is member HIV positive? **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: _____

☐ Melanoma

a. Is the melanoma recurrent, in situ (in the original position or place) or neither?

- ❑ Recurrent
  - Does member have local, satellite and/or in-transit recurrence? **Yes or No**
  - Has diagnosis been confirmed by FNA (Fine needle aspiration) or biopsy? **Yes or No**
  - Is clinical trial an option? **Yes or No**
  - Does the member have superficial dermal lesions (very low volume cutaneous metastases)? **Yes or No**
- ❑ In situ (including Lentigo Maligna, also known as Hutchinson melanotic freckle)
  -
  - Did the member have positive margins after optimal surgery? **Yes or No**
- ❑ Neither
  - Does member have stage III, in-transit or locally metastatic melanoma? **Yes or No**
  - Has diagnosis been confirmed by FNA (Fine needle aspiration) or biopsy? **Yes or No**
  - Is clinical trial an option? **Yes or No**
  - Does the member have superficial dermal lesions (very low volume cutaneous metastases)? **Yes or No**

☐ Bowen's Disease (squamous cell carcinoma in situ)

a. Is the disease considered low risk? **Yes or No**

b. Is surgery or radiation contraindicated or medically less appropriate?

☐ Mycosis Fungoides (MF) or Sezary Syndrome (SS)

a. Is the disease regional or localized (limited/localized skin involvement)? **Yes or No**

b. Is disease stage 1A (T1, N0,M0,B 0,1)? **Yes or No**

☐ Primary Cutaneous Marginal Zone Lymphoma (PC-MZL) or Primary Cutaneous Follicle Center Cell Lymphoma (PC-FCL)

a. Please indicate if the member has one of the following:

- □ Solitary lesions (T1)
- □ Regional disease (T2)
- □ Ann Arbor Stage IE (localized region, not in the lymph nodes or has spread lymph nodes to adjacent tissue)
- □ Generalized skin lesions (T3)
- □ Other:_____

☐ Penile Cancer

a. Does the member have one of the following:

- □ Wart-like (Ta) carcinoma
- □ Carcinoma in situ (Tis)
- □ None

☐ AIDS-Related Kaposi Sarcoma

a. Does the member have limited cutaneous disease that is either symptomatic or cosmetically unacceptable? **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

Imiquimod (Aldara) – Medical Necessity Request

*****Complete page 3 only for Subsequent/Renewal requests*****

1. Has member shown response to therapy or had clinical improvement? **Yes or No**

2. Diagnosis Information (please indicate diagnosis and answer related questions):

☐ Vaginal Intraepithelial Neoplasia (VIN)

☐ Melanoma

a. Does the member have one of the following types:
   - □ In situ, including Lentigo maligna
   - □ Stage 3 Melanoma

☐ Molluscum contagiosum

☐ Bowen's Disease (squamos cell carcinoma in situ)

a. Is the disease considered low risk? Yes or No

☐ Mycosis Fungoides (MF) or Sezary Syndrome (SS)

c. Is the disease regional or localized? **Yes or No**

☐ Primary Cutaneous Marginal Zone Lymphoma (PC-MZL) or Primary Cutaneous Follicle Center Cell Lymphoma (PC-FCL)

a. Please indicate which of the following the member has:
   - □ Solitary lesions (T1)
   - □ Regional disease (T2)
   - □ Ann Arbor Stage IE (localized region, not in the lymph nodes or has spread lymph nodes to adjacent tissue)
   - □ Generalized skin lesions (T3)
   - □ Other:_____

☐ Penile Cancer

☐ AIDS-Related Kaposi Sarcoma

Physician office's signature*_____ Print Name_____

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