Premier Health Plan

Premier Health Plan
Pharmacy Services
Commercial Phone: 855-266-0713
Exchange Phone: 866-822-2413
Fax: 855-862-6518

REMICADE
Prior Authorization Form

☐ Standard Request ☐ Expedited Request	If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. ***For state exchanges only:*** The above disclaimer applies for exigent circumstances. Expedited review may also be requested when you are undergoing a current course of treatment using a non-formulary drug.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Directions:
Quantity Dispensed:	Day Supply:	☐ Generic ☐ Brand Necessary

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

☐ New medication ☐ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.

Billing Information

☐ Billed by **PHARMACY** delivered to the member *or* provider for administration. Specialty Pharmacy:__________________	☐ Billed under **MEDICAL** benefit by provider. JCODE:__J1745____ ICD-10 Code:__________________	Place of Administration: ☐ Physician's Office ☐ Hospital/Clinic ☐ Patient Home

Clinical Information

Disease Severity: ☐ Mild ☐ Moderate ☐ Severe	PPD (tuberculin) test: ☐ Positive ☐ Negative Date:________________	Is the member currently using another TNF-blocking or biologic agent in combination with Remicade? ☐ Yes ☐ No Medication:____

Does the member currently have evidence of infection? ☐ Yes ☐ No

Please indicate the diagnosis on the left and complete the corresponding questions.

☐Rheumatoid Arthritis

Has the member tried and failed Methotrexate for at least 3 months? ☐Yes ☐No

Please indicate if the member tried and failed any of the following for at least *3 months*

Medication	Dates on Therapy	Dose	Reason for Discontinuing
☐Methotrexate			
☐Leflunomide (Arava)			
☐Sulfasalazine (Azulfidine)			
☐Minocycline (Minocin)			
☐Hydroxychlorquine (Plaquenil)			

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Member Name:	DOB:	Health Plan ID:

Please be sure to complete and include this page with the 1st page of this form.

☐ Psoriatic Arthritis

Is the members disease dominant: ☐ Peripheral ☐ Axial
Has the member tried and failed any NSAIDs for at least 3 months? ☐Yes ☐No

Please indicate if the member tried and failed any of the following for at least *3 months*

Medication	Dates on Therapy	Dose	Reason for Discontinuing
☐NSAIDs			
☐Methotrexate			
☐ Cyclosporine (Neoral)			
☐Sulfasalazine (Azulfidine)			
☐ Leflunomide (Arava)			

☐ Ankylosing Spondylosis

Is the members disease dominant: ☐ Peripheral ☐ Axial
Has the member tried and failed any NSAIDs for at least 3 months? ☐Yes ☐No

Please indicate if the member tried and failed any of the following for at least *3 months*

Medication	Dates on Therapy	Dose	Reason for Discontinuing
☐Methotrexate			
☐Sulfasalazine (Azulfidine)			
☐Other			

☐ Plaque Psoriasis

Has the member tried and failed any topical treatment? ☐Yes ☐No
Does the member have psoriasis on the palms, soles, head, neck, or genitalia? ☐Yes ☐No
Has the member tried and failed phototherapy or photochemotherapy? ☐Yes ☐No
Please indicate body surface area (BSA) involvement: ☐Less than 10% ☐Greater than or equal to 10%

Please indicate if the member tried and failed any of the following for at least *3 months*?

Medication	Dates on Therapy	Dose	Reason for Discontinuing
☐Topical:_________________			
☐Methotrexate			
☐ Cyclosporine (Neoral, Sandimmune)			
☐ Acitretin (Soriatane)			

☐Crohn's Disease

Has the member tried and failed Corticosteroids? ☐Yes ☐No

Please indicate if the member tried and failed any of the following for at least *3 months*

Medication	Dates on Therapy	Dose	Reason for Discontinuing
☐Corticosteroids			
☐Azathioprine (Imuran)			
☐6-mercaptopurine (Purinethol)			
☐Other:			

☐ Ulcerative Colitis

Has the member tried and failed Corticosteroids? ☐Yes ☐No

Please indicate if the member tried and failed any of the following for at least *3 months*

Medication	Dates on Therapy	Dose	Reason for Discontinuing
☐Corticosteroids			
☐Azathioprine (Imuran)			
☐6-mercaptopurine (Purinethol)			
☐ Sulfasalzine (Azulfidine)			
☐ Mesalamine (Asacol)			
☐ Other:			

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