

REMICADE Prior Authorization Form

<input type="checkbox"/> Standard Request (72 hours) <input type="checkbox"/> Expedited Request (24 hours)	If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received.
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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: Remicade	Strength:	Directions:
Quantity Dispensed:	Day Supply:	<input type="checkbox"/> Generic <input type="checkbox"/> Brand Necessary
<i>Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.</i>		
<input type="checkbox"/> New medication <input type="checkbox"/> 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

<input type="checkbox"/> Billed by PHARMACY delivered to the member or provider for administration. Specialty Pharmacy: _____	<input type="checkbox"/> Billed under MEDICAL benefit by provider. JCODE: <u> J1745 </u> ICD-10 Code: _____	Place of Administration: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital/Clinic <input type="checkbox"/> Patient Home
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Clinical Information

Disease Severity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	PPD (tuberculin) test: <input type="checkbox"/> Positive <input type="checkbox"/> Negative Date: _____	Is the member currently using another TNF-blocking or biologic agent in combination with Remicade? <input type="checkbox"/> Yes <input type="checkbox"/> No Medication: _____
Does the member currently have evidence of infection? <input type="checkbox"/> Yes <input type="checkbox"/> No		
What is the patient weight (within last 3 months)? _____		

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

<input type="checkbox"/> Rheumatoid Arthritis	Has the member tried and failed Methotrexate for at least 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Please indicate if the member tried and failed any of the following for at least <u>3 months</u>			
	Medication	Dates on Therapy	Dose	Reason for Discontinuing
	<input type="checkbox"/> Methotrexate			
	<input type="checkbox"/> Leflunomide (Arava)			

	<input type="checkbox"/> Sulfasalazine (Azulfidine)			
	<input type="checkbox"/> Hydroxychlorquine (Plaquenil)			
<input type="checkbox"/> Psoriatic Arthritis	Is the members disease dominant: <input type="checkbox"/> Peripheral <input type="checkbox"/> Axial			
	Has the member tried and failed any NSAIDs for at least 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> 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
	<input type="checkbox"/> NSAIDs			
	<input type="checkbox"/> Methotrexate			
	<input type="checkbox"/> Cyclosporine (Neoral)			
<input type="checkbox"/> Sulfasalazine (Azulfidine)				
<input type="checkbox"/> Leflunomide (Arava)				
<input type="checkbox"/> Ankylosing Spondylosis	Has the member tried and failed therapy with two NSAIDs? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Please indicate if the member tried and failed any of the following			
	Medication	Dates on Therapy	Dose	Reason for Discontinuing
	<input type="checkbox"/> NSAID #1:			
	<input type="checkbox"/> NSAID #2:			
<input type="checkbox"/> Other				
<input type="checkbox"/> Plaque Psoriasis	Has the member tried and failed any topical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Does the member have psoriasis on the palms, soles, head, neck, or genitalia? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Has the member tried and failed phototherapy or photochemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Please indicate body surface area (BSA) involvement: <input type="checkbox"/> Less than 5% <input type="checkbox"/> Greater than or equal to 5%			
	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
	<input type="checkbox"/> Topical: _____			
<input type="checkbox"/> Methotrexate				
<input type="checkbox"/> Cyclosporine (Neoral, Sandimmune)				
<input type="checkbox"/> Acitretin (Soriatane)				
<input type="checkbox"/> Crohn's Disease	Has the member tried and failed Corticosteroids? <input type="checkbox"/> Yes <input type="checkbox"/> 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
	<input type="checkbox"/> Corticosteroids			
	<input type="checkbox"/> Azathioprine (Imuran)			
<input type="checkbox"/> 6-mercaptopurine (Purinethol)				
<input type="checkbox"/> Other:				
<input type="checkbox"/> Ulcerative Colitis	Has the member tried and failed Corticosteroids? <input type="checkbox"/> Yes <input type="checkbox"/> 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
	<input type="checkbox"/> Corticosteroids			
	<input type="checkbox"/> Azathioprine (Imuran)			
	<input type="checkbox"/> 6-mercaptopurine (Purinethol)			
<input type="checkbox"/> Sulfasalzine (Azulfidine)				
<input type="checkbox"/> Mesalamine (Asacol)				
Please provide any additional information which should be considered in the space below:				