

Pharmacy Prior Authorization Form

Last Reviewed: Sept 11

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Remicade[®] (infliximab) Urgent Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

Remicade 100 mg vial

Dose: _____ Start date: _____

Place of administration:

Self-administered

Provider's Office

Outpatient Infusion Center Name of center: _____

Home Infusion Name of agency: _____

Billing options:

Physician buy and bill (J1745)

Preferred Specialty Vendor

Other: _____

Prescriber is a Rheumatologist, Gastroenterologist, or Dermatologist:

Yes

No

Priority Health Precertification Requirements:

Authorization of Remicade requires:

- One of the following diagnoses:
 1. Rheumatoid arthritis
 - Must have a documented therapeutic trial with at least one self injectable anti-TNF
 - Documented therapeutic trial of at least one DMARD
 - Patient must be treated with methotrexate following Remicade infusions
 2. Psoriatic arthritis
 - Must have a documented therapeutic trial with at least one self injectable anti-TNF
 - Documented therapeutic trial of at least one DMARD

3. Ankylosing spondylitis
 - Must have a documented therapeutic trial with at least one self injectable anti-TNF
 - Presence of active disease of at least 4 weeks
 - BASDAI score of at least 4
 - Documented therapeutic trial and failure of at least two NSAIDs during a single 3-month period
 - Documented therapeutic trial of intra-articular steroids
 - Documented therapeutic trial of sulfasalazine
 4. Severe (extensive or disabling) plaque psoriasis
 - Must have a documented therapeutic trial with at least one self injectable anti-TNF
 - Involvement of greater than 10% of body surface area (unless hands, feet, head, neck, or genitalia are involved)
 - Documented therapeutic trial of one or more topical agents
 - Documented therapeutic trial of phototherapy
 - Documented therapeutic trial of one or more systemic treatments
 5. Active Crohn's Disease
 - Must have a documented therapeutic trial and clinical failure with Humira
 - Documented therapeutic trial of **or** is currently on steroid therapy
 - Patient must be treated with an immunomodulator (methotrexate, azathioprine, or 6-mercaptopurine) following the Remicade infusion
 6. Fistulizing Crohn's Disease
 - Treatment for a new fistula unresponsive to standard treatment (azathioprine, 6-mercaptopurine) for a minimum of three months
 - Treatment for a recurrent fistula previously treated with Remicade
 7. Ulcerative Colitis
 - Moderate to severe attack
 - Documented therapeutic trial of at least one of the following: aminosalicylates, steroids, azathioprine, 6-mercaptopurine
- Negative TB test (must be done yearly)
 - Patient must **not** have moderate to severe heart failure

Continuation of Remicade therapy requires:

- Patient must be compliant taking the medication as prescribed
- Patient must be tolerating the medication
- Patient must not be experiencing any severe adverse reactions while taking the medication
- Patient must be responding positively to the medication
- Patient must have a negative TB test within the past 12 months

Please Complete the Following Information:

Diagnosis:

- Rheumatoid Arthritis– ICD code: _____
- Psoriatic Arthritis– ICD code: _____
- Ankylosing Spondylitis– ICD code: _____
- Plaque psoriasis– ICD code: _____
- Active Crohn's Disease– ICD code: _____
- Fistulizing Crohn's Disease– ICD code: _____
- Ulcerative Colitis– ICD code: _____
- Other: _____ – ICD code: _____ Please provide rationale for use:

Patient's age: _____

Patient's weight: _____

Results of annual (within the past 12 months) TB test:

- Positive
- Negative Date: _____
- Test not done – Rationale for use: _____

Patient has moderate to severe heart failure:

- Yes – Rationale for use: _____
- No

New request or continuation of therapy:

- New (see section 1)
- Continuation (see section 2)

Section 1 – New requests:

Rheumatoid Arthritis or Psoriatic Arthritis

Patient has had a therapeutic trial with at least one self injectable anti-TNF

Patient has had a therapeutic trial of at least one of the following DMARDS:

Yes

	Dose	Dates	Outcome
<input type="checkbox"/> azathioprine	_____	_____	_____
<input type="checkbox"/> Cyclosporine	_____	_____	_____
<input type="checkbox"/> d-penicillamine	_____	_____	_____
<input type="checkbox"/> gold sodium thiomalate	_____	_____	_____
<input type="checkbox"/> auranofin	_____	_____	_____
<input type="checkbox"/> aurothioglucose	_____	_____	_____
<input type="checkbox"/> hydroxychloroquine	_____	_____	_____
<input type="checkbox"/> leflunomide	_____	_____	_____
<input type="checkbox"/> methotrexate	_____	_____	_____
<input type="checkbox"/> sulfasalazine	_____	_____	_____

No – Rationale for use: _____

Patient will be treated with methotrexate following the Remicade infusion:

- Yes
- No – Rationale for use: _____

Ankylosing Spondylitis

Patient has had a therapeutic trial with at least one self injectable anti-TNF

Patient has shown presence of active disease for at least 4 weeks:

- Yes
- No – Rationale for use: _____

Patient has had a sustained BASDAI of at least 4:

- Yes
 No – Rationale for use: _____

BASDAI score: _____

Patient has had a therapeutic trial of at least two NSAIDs during a single 3-month period:

- Yes
NSAID: _____ Dose: _____ Trial dates: _____
NSAID: _____ Dose: _____ Trial dates: _____
- No – Rationale for use: _____

Patient has had a therapeutic trial of intra-articular steroids and sulfasalazine:

- Yes
Drug: _____ Dose: _____ Trial dates: _____
Drug: _____ Dose: _____ Trial dates: _____
- No – Rationale for use: _____

Plaque Psoriasis

- Patient has had a therapeutic trial with at least one self injectable anti-TNF

Plaque affects > 10% of the patient's body surface area:

- Yes
 No

Plaque psoriasis affects the hand, feet, head, neck, or genitalia:

- Yes
 No

Patient has had a documented trial and clinical failure of one or more topical agents:

- Yes
Drug: _____ Dose: _____ Trial dates: _____
Drug: _____ Dose: _____ Trial dates: _____
- No – Rationale for use: _____

Patient has had a documented trial and clinical failure with phototherapy (UVA, UVB):

- Yes
Type of therapy: _____ Trial dates: _____
- No – Rationale for use: _____

Patient has had a documented trial and clinical failure of one or more systemic treatments (azathioprine, Neoral, methotrexate, cyclosporine, Soriatane):

- Yes
Drug: _____ Dose: _____ Trial dates: _____
Drug: _____ Dose: _____ Trial dates: _____
- No – Rationale for use: _____

Patient has a contraindication to systemic treatments:

- Yes - List the contraindication: _____
- No

Active Crohn's Disease
 Patient has had a therapeutic trial and clinical failure with Humira

Patient has had a documented therapeutic trial and clinical failure of **or** is currently on steroid therapy:

 Yes

Drug: _____ Dose: _____ Trial dates: _____
 Drug: _____ Dose: _____ Trial dates: _____

 No – Rationale for use: _____

Patient will be treated with an immunomodulator (methotrexate, azathioprine, or 6-mercaptopurine) following the Remicade infusion:

 Yes

 No – Rationale for use: _____

 Fistulizing Crohn's Disease

This is a new fistula unresponsive to standard treatment (azathioprine, 6-mercaptopurine) for a minimum of three months:

 Yes

 No

This is a recurrent fistula previously treated with Remicade:

 Yes

 No

 Ulcerative Colitis

The ulcerative colitis is moderate to severe:

 Yes

 No – Rationale for use: _____

Patient has had a documented trial and clinical failure of at least one of the following:

 Yes

	Dose	Dates	Outcome
<input type="checkbox"/> aminosalicylates	_____	_____	_____
<input type="checkbox"/> steroids	_____	_____	_____
<input type="checkbox"/> azathioprine	_____	_____	_____
<input type="checkbox"/> 6-mercaptopurine	_____	_____	_____

 No – Rationale for use: _____

Section 2 – Requests for continuation of therapy:
 The patient is compliant in taking the medication as scheduled

 The patient tolerated the medication

 The patient did not experience any severe adverse reactions while taking the medication

 The patient has responded to treatment, as determined by the prescribing physician

 The patient has had a negative TB test result within the past 12 months Date of test: _____

*** All fields must be complete and legible for Prior Authorization Review***

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX