

REMICADE (infliximab)

SPECIALTY PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Patient Information	
Name:	Member ID #:
Group Name:	Date of Birth:
Diagnosis:	Diagnosis Code:

Provider Information	
Prescriber's Name:	Prescriber's DEA #:
Phone:	Fax:
Office Address:	

Complete and review information, sign and date. Fax signed form to Caremark Specialty's prior authorization department at 1-866-249-6155. The Caremark fax machine is located in a secure location as required by HIPAA regulations. On behalf of the member's health plan, Caremark assists in the administration of the prior authorization program. Caremark is an independent company that administers prescription drug benefits.

Providers may call Caremark at 1-866-814-5506 with any questions concerning prior authorization procedures. For questions related to the patient's eligibility, drug copay or delivery, providers and members should call Caremark Specialty Customer Care at 1-866-513-5214 with any questions. Members may also call their health plan at the number indicated on their Member ID cards.

Please check or circle the appropriate answer for each applicable question (Y for Yes, N for No).

1. What drug is being prescribed? Remicade
2. What is the **primary** diagnosis?

<input type="checkbox"/> Rheumatoid Arthritis (RA)	<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Juvenile Idiopathic Arthritis (JIA)	<input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> Uveitis
<input type="checkbox"/> Psoriatic Arthritis	<input type="checkbox"/> Behcet's Syndrome	<input type="checkbox"/> Other _____
<input type="checkbox"/> Ankylosing Spondylitis	<input type="checkbox"/> Wegener's Granulomatosis	
<input type="checkbox"/> Hidradenitis Suppurativa	<input type="checkbox"/> Pyoderma Gangrenosum	
3. What is the ICD-9? _____
4. Prior to initiating therapy, has the patient been screened for latent tuberculosis (TB) infection with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB) Y N
5. What the test result Positive or Negative? Positive Negative
[If the answer is negative, skip to question 8.]

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6. If positive, has active Tuberculosis (TB) been ruled out? Y N
7. Is the patient currently receiving or has completed treatment for latent Tuberculosis (TB)? (i.e., antibiotic prophylaxis) Y N
8. Is patient at risk for Hepatitis B Virus (HBV) infection? Y N
9. Prior to initiating therapy, has HBV infection been ruled out or treatment initiated? Y N
10. Does the patient have an active infection (chronic or localized)? Y N
11. Does the patient have unstable moderate to severe heart failure? Y N
12. If patient received treatment with Remicade previously, did the patient experience a severe hypersensitivity reaction? Y N N/A (new to therapy)
13. **Will Remicade be used in combination with another biologic agent?** (i.e., with Actemra, Cimzia, Enbrel, Humira, Kineret, Orencia, Rituxan or Simponi) Y N
14. Will Remicade be used in combination with methotrexate? Y N
15. Will Remicade be used in combination with leflunomide (Arava)? Y N
16. If No, **document the clinical reason to NOT use MTX and/or Arava:**

17. If the patient's diagnosis is JIA, what form of JIA does the patient have?
 Polyarticular JIA (i.e., affecting 5 or more joints)
 Systemic-onset JIA (i.e., characterized by arthritis, fever, rash and organ involvement)
 Other form of JIA: _____
18. Is the patient currently receiving Remicade? Y N
If yes, skip to question 42.

**Complete the section designated for the patient's diagnosis.*

SECTION A: Rheumatoid Arthritis (RA)

19. What is the initial dosing of Remicade? Initial dose is 3-5 mg/kg Other _____ **mk/kg**
20. If initial dose was indicated as **Other**, will the dose be changed to 3-5 mg/kg? Y N
21. Has the patient received a prior biologic therapy for Rheumatoid Arthritis (RA)? Y N
Indicate biologic therapy previously tried.
 Actemra Cimzia Enbrel Humira Kineret Orencia
 Rituxan Simponi
22. Has the patient completed an adequate trial of methotrexate (MTX)? Y N
If no, skip to #24.

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23. Was the MTX dose/route optimized without adequate response? Y N

24. Is the patient contraindicated or intolerant to MTX?

Contraindicated to MTX* Intolerant to MTX No (Neither)

*Document Contraindication to MTX. _____

25. Has the patient failed to respond to or tolerate adequate therapeutic trial of another non-biologic disease modifying antirheumatic drug (DMARD)? Y N
If no, skip to #27.

26. Document the non-biologic DMARD **AND** the length of therapy that the patient has tried OR had insufficient response to:

DMARD: _____ Length of Therapy: _____

27. Is the patient contraindicated or intolerant to non-biologic DMARDs?

Contraindicated to non-biologic DMARDs* Intolerant to non-biologic DMARDs No (Neither)

*Document Contraindication to non-biologic DMARDs: _____

28. Does the patient have severely active RA that warrants Remicade as first-line therapy? Y N

SECTION B: Ankylosing Spondylitis

29. Has the patient tried and had an inadequate response to **at least 2** non-steroidal anti-inflammatory drugs (NSAIDs)? Y N

30. Is the patient contraindicated or intolerant to NSAIDs?

Contraindicated to NSAIDs* Intolerant to NSAIDs No (Neither)

*Document Contraindication to NSAIDs: _____

SECTION C: Crohn's Disease or Ulcerative Colitis

31. Has patient tried and had inadequate response to conventional therapy? Y N
If yes, skip to #33.

32. If No, document clinical reason patient has not had a trial of conventional therapies: _____

33. Document **ALL** previous treatment regimen(s):

Sulfasalazine (Azulfidine, Sulfazine) Azathioprine (Azasan, Imuran) Cimzia
 Mesalamine, oral (Asacol, Pentasa) Mercaptopurine (Purinethol) Humira
 Metronidazole (Flagyl) Methotrexate Other _____
 Prednisone Hydrocortisone, IV (Solu-Cortef)
 Budesonide (Entocort EC) Cyclosporine, IV (Sandimmune)

SECTION D: Psoriasis

34. Has the patient received any prior biologic therapy for psoriasis? Y N
Indicate biologic therapy previously tried.

Amevive Humira Remicade Stelara

35. What is the percentage of Body Surface Area (BSA) affected? _____ %

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36. Does the patient's psoriasis affect crucial body areas or cause disruption of daily activities (i.e. hands, feet, face, neck and/or groin)? Y N

37. Has the patient tried and had an insufficient response to either phototherapy or oral conventional systemic therapy?
If Yes, skip to #40. Y N

38. Is there a clinical reason to avoid these therapies (phototherapy/conventional systemic therapy) as initial treatments? Y N

39. If Yes, Document clinical reason to avoid these therapies:

40. Document previous therapies that the patient has tried or had insufficient response to:

Phototherapy Cyclosporine Other systemic therapy: _____

Methotrexate Acitrecin

41. Has the dose been optimized without adequate response? Y N

SECTION E: Continuation or Re-Authorization of Remicade Psoriasis

(Only answer below questions if patient is currently on Remicade)

42. Has the patient been receiving Remicade for **at least** 6 months? Y N

43. **Document length of therapy:** _____

44. Has the patient's condition improved or stabilized on Remicade? Y N

45. If No, document the clinical reason for lack of improvement:

46. **If patient's diagnosis is RA**, has the patient achieved remission or low disease activity? Y N

47. **If diagnosis is Psoriasis**, document the current affected percent Body Surface Area (%BSA): _____%

Comments:

I affirm that the information given on this form is accurate as of this date.

Prescriber (or Authorized) Signature and Date:
