

# Remicade

## Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.  
Otherwise please return completed form to:  
UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-979-UPMC (8762) FAX 412-454-7722

### PLEASE TYPE OR PRINT NEATLY

Please complete all sections of this form. Incomplete responses may delay this request.

Office Contact:		Provider Specialty:		
Provider First Name:		Provider Last Name:		
Provider Phone:		Provider Fax:		Provider NPI #:
Patient Name:		Patient UPMC Health Plan ID Number:		Patient DOB:
Drug Requested:	Strength:	Frequency:	Qty Dispensed:	Patient Age:

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

<input type="checkbox"/> New medication	If ongoing, provide date started:	If medication is ongoing, Did the member show improvement while on therapy?	<input type="checkbox"/> Yes
<input type="checkbox"/> Ongoing medication			<input type="checkbox"/> No

Diagnosis:	Date of diagnosis:
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Please indicate place of administration/ infusion:	<input type="checkbox"/> Physician's Office	Please indicate how medication will be billed:
	<input type="checkbox"/> Hospital/Facility	
Please provide facility/provider name and address:		<input type="checkbox"/> Billed directly by the provider via JCODE Provide JCODE: _____
		<input type="checkbox"/> Billed by a pharmacy and delivered to the provider
		<input type="checkbox"/> Billed by a pharmacy and delivered to the patient

### Please complete the following questions for all diagnoses.

Please indicate disease severity:  Mild  Moderate  Severe

Is there evidence of infection?  Yes  No

Date of PPD (tuberculin) test: \_\_\_\_\_ Result of PPD test:  Positive  Negative

Is the member currently using another TNF-blocking agent or biologic agent in combination with Remicade?  Yes  No

If yes, please indicate drug name: \_\_\_\_\_

### 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 provide dates of therapy and dose:	
	Reason for discontinuation:	
	Please indicate if the member tried and failed any of the following for at least 3 months?	
	<input type="checkbox"/> Leflunomide (Arava)	<input type="checkbox"/> Minocycline
	<input type="checkbox"/> Sulfasalazine (Azulfidine)	<input type="checkbox"/> Hydroxychloroquine (Plaquenil)
	Please provide dates of therapy and dose:	
	Reason for discontinuation:	
<input type="checkbox"/> Psoriatic Arthritis	Does the member have dominant <b>peripheral</b> disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Does the member have dominant <b>axial</b> disease?	<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?	
	<input type="checkbox"/> Methotrexate	<input type="checkbox"/> Cyclosporine (Neoral)
	<input type="checkbox"/> Sulfasalazine (Azulfidine)	<input type="checkbox"/> Leflunomide ( Arava)
	Please provide dates of therapy and dose:	
	Reason for discontinuation:	
	Has the member tried and failed any NSAIDs for at least 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, please indicate drug name(s): _____	
	Please provide dates of therapy and dose:	
	Reason for discontinuation:	

Please be sure to complete and include the 2<sup>nd</sup> page of this form

**Remicade  
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<b>Patient Name</b>	<b>Patient UPMC Health Plan ID Number:</b>	<b>Patient DOB:</b>
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**Please be sure to complete and include this page with the 1<sup>st</sup> page of this form**

<input type="checkbox"/> Ankylosing Spondylitis	Does the member have dominant <b>peripheral</b> disease?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Does the member have dominant <b>axial</b> disease?		<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?		
	<input type="checkbox"/> Methotrexate	<input type="checkbox"/> Sulfasalazine (Azulfidine)	
	Please provide dates of therapy and dose:		
	Reason for discontinuation:		
	Has the member tried and failed any NSAIDs for at least 3 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, please indicate drug name(s): Please provide dates of therapy and dose:		
Reason for discontinuation:			
<input type="checkbox"/> Plaque Psoriasis	Please indicate body surface area (BSA) involvement:		<input type="checkbox"/> Less than 10% <input type="checkbox"/> Greater than or equal to 10%
	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 topical treatments?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, indicate drug name(s):		
	Reason for discontinuation:		
	Has the member tried phototherapy or photochemotherapy		<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?		
	<input type="checkbox"/> Methotrexate	<input type="checkbox"/> Cyclosporine (Neoral, Sandimmune)	<input type="checkbox"/> Acitretin (Soriatane)
Please provide dates of therapy and dose:			
Reason for discontinuation:			
<input type="checkbox"/> Crohn's Disease	Has the member tried and failed Corticosteroids?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, please provide dates of therapy and dose:		
	Reason for discontinuation:		
	Please indicate if the member tried and failed any of the following for at least 3 months?		
	<input type="checkbox"/> Azathioprine (Imuran)	<input type="checkbox"/> 6-mercaptopurine (Purinethol)	
	<input type="checkbox"/> Other, Please list drug name:		
Please provide dates of therapy and dose:			
Reason for discontinuation:			
<input type="checkbox"/> Ulcerative Colitis	Has the member tried and failed Corticosteroids?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, please provide dates of therapy and dose:		
	Reason for discontinuation:		
	Please indicate if the member tried and failed any of the following for at least 3 months?		
	<input type="checkbox"/> Sulfasalazine (Azulfidine)	<input type="checkbox"/> Mesalamine (Asacol)	<input type="checkbox"/> Azathioprine (Imuran)
	<input type="checkbox"/> 6-mercaptopurine (Purinethol))		<input type="checkbox"/> Other, Please list drug name:
	Please provide dates of therapy and dose:		
Reason for discontinuation:			

**Please provide any additional information which should be considered in the space below:**
