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.

☐ **New medication** ☐ **Ongoing medication**	**If ongoing, provide date started:**	**If medication is ongoing, did the member show improvement while on therapy?**	☐ **Yes** ☐ **No**

Diagnosis:	**Date of diagnosis:**
Please indicate place of administration/ infusion: ☐ Physician's Office ☐ Hospital/Facility ☐ Patient Home	**Please indicate how medication will be billed:** ☐ Billed directly by the provider via JCODE Provide JCODE:_____ ☐ Billed by a pharmacy and delivered to the provider ☐ Billed by a pharmacy and delivered to the patient
Please provide facility/provider name and address:	

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.

☐ Rheumatoid Arthritis	Has the member tried and failed Methotrexate for at least 3 months?	☐ Yes ☐ 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?	
	☐ Leflunomide (Arava) ☐ Minocycline ☐ Sulfasalazine (Azulfidine) ☐ Hydroxychloroquine (Plaquenil)	
	Please provide dates of therapy and dose:	
	Reason for discontinuation:	
☐ Psoriatic Arthritis	Does the member have dominant **peripheral** disease?	☐ Yes ☐ No
	Does the member have dominant **axial** disease?	☐ Yes ☐ No
	Please indicate if the member tried and failed any of the following for at least 3 months?	
	☐ Methotrexate ☐ Cyclosporine (Neoral) ☐ Sulfasalazine (Azulfidine) ☐ 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? If yes, please indicate drug name(s):	☐ Yes ☐ No
	Please provide dates of therapy and dose:	
	Reason for discontinuation:	

Please be sure to complete and include the 2nd page of this form

Remicade
Page 2

Patient Name	**Patient UPMC Health Plan ID Number:**	**Patient DOB:**

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

☐Ankylosing Spondylitis	Does the member have dominant **peripheral** disease?		☐Yes ☐No
	Does the member have dominant **axial** disease?		☐Yes ☐No
	Please indicate if the member tried and failed any of the following for at least 3 months?		
	☐Methotrexate	☐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?		☐Yes ☐No
	If yes, please indicate drug name(s):		
	Please provide dates of therapy and dose:		
	Reason for discontinuation:		
☐Plaque Psoriasis	Please indicate body surface area (BSA) involvement:	☐Less than 10%	☐Greater than or equal to 10%
	Does the member have psoriasis on the palms, soles, head, neck, or genitalia?		☐Yes ☐No
	Has the member tried and failed topical treatments?		☐Yes ☐No
	If yes, indicate drug name(s):		
	Reason for discontinuation:		
	Has the member tried phototherapy or photochemotherapy		☐Yes ☐No
	Please indicate if the member tried and failed any of the following for at least 3 months?		
	☐Methotrexate	☐Cyclosporine (Neoral, Sandimmune)	☐Acitretin (Soriatane)
	Please provide dates of therapy and dose:		
	Reason for discontinuation:		
☐Crohn's Disease	Has the member tried and failed corticosteroids?		☐Yes ☐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?		
	☐Azathioprine (Imuran)	☐6-mercaptopurine (Purinethol)	
	☐Other, Please list drug name:		
	Please provide dates of therapy and dose:		
	Reason for discontinuation:		
☐Ulcerative Colitis	Has the member tried and failed corticosteroids?		☐Yes ☐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?		
	☐Sulfasalzine (Azulfidine)	☐Mesalamine (Asacol)	☐Azathioprine (Imuran)
	☐6-mercaptopurine (Purinethol)	☐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: