MedStar Medicare Choice

MedStar Medicare Choice
Pharmacy Services
Phone: 855-266-0712
Fax: 855-862-6517

# REMICADE
## Prior Authorization Form

| | |
|---|---|
| □ Standard Request (72 hours)<br>□ 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. |

## 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:<br>Remicade | Strength: | Directions: |
| Quantity Dispensed: | Day Supply: | □ Generic<br>□ Brand Necessary |

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

| | | |
|---|---|---|
| □ New medication<br>□ 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

| | | |
|---|---|---|
| □ Billed by **PHARMACY** delivered to the member *or* provider for administration.<br><br>Specialty Pharmacy:_____ | □ Billed under **MEDICAL** benefit by provider.<br>JCODE:__J1745____<br>ICD-10 Code:_____ | Place of Administration:<br>□ Physician's Office<br>□ Hospital/Clinic<br>□ Patient Home |

## Clinical Information

Disease Severity:
□ Mild
□ Moderate
□ Severe

PPD (tuberculin) test:
□ Positive
□ Negative
Date:_____

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

Does the member currently have evidence of infection? □ Yes □ No

What is the patient weight (within last 3 months)? _____

**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 indicate if the member tried and failed any of the following for at least *3 months***

| Medication | Dates on Therapy | Dose | Reason for Discontinuing |
|---|---|---|---|
| □Methotrexate | | | |
| □Leflunomide (Arava) | | | |
| □Sulfasalazine (Azulfidine) | | | |
| □Hydroxychlorquine (Plaquenil) | | | |



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<table>
<tr><td rowspan="7">☐ Psoriatic Arthritis</td><td colspan="4">Is the members disease dominant: ☐ Peripheral ☐ Axial<br>Has the member tried and failed any NSAIDs for at least 3 months? ☐Yes ☐No</td></tr>
<tr><td colspan="4">Please indicate if the member tried and failed any of the following for at least 3 months</td></tr>
<tr><td>Medication</td><td>Dates on Therapy</td><td>Dose</td><td>Reason for Discontinuing</td></tr>
<tr><td>☐NSAIDs</td><td></td><td></td><td></td></tr>
<tr><td>☐Methotrexate</td><td></td><td></td><td></td></tr>
<tr><td>☐Cyclosporine (Neoral)</td><td></td><td></td><td></td></tr>
<tr><td>☐Sulfasalazine (Azulfidine)</td><td></td><td></td><td></td></tr>
<tr><td>☐Leflunomide (Arava)</td><td></td><td></td><td></td></tr>
<tr><td rowspan="5">☐ Ankylosing Spondylosis</td><td colspan="4">Has the member tried and failed therapy with two NSAIDs? ☐Yes ☐No</td></tr>
<tr><td colspan="4">Please indicate if the member tried and failed any of the following</td></tr>
<tr><td>Medication</td><td>Dates on Therapy</td><td>Dose</td><td>Reason for Discontinuing</td></tr>
<tr><td>☐NSAID #1:</td><td></td><td></td><td></td></tr>
<tr><td>☐NSAID #2:</td><td></td><td></td><td></td></tr>
<tr><td>☐Other</td><td></td><td></td><td></td></tr>
<tr><td rowspan="7">☐ Plaque Psoriasis</td><td colspan="4">Has the member tried and failed any topical treatment? ☐Yes ☐No<br>Does the member have psoriasis on the palms, soles, head, neck, or genitalia? ☐Yes ☐No<br>Has the member tried and failed phototherapy or photochemotherapy? ☐Yes ☐No<br>Please indicate body surface area (BSA) involvement: ☐Less than 5% ☐Greater than or equal to 5%</td></tr>
<tr><td colspan="4">Please indicate if the member tried and failed any of the following for at least 3 months?</td></tr>
<tr><td>Medication</td><td>Dates on Therapy</td><td>Dose</td><td>Reason for Discontinuing</td></tr>
<tr><td>☐Topical:_____</td><td></td><td></td><td></td></tr>
<tr><td>☐Methotrexate</td><td></td><td></td><td></td></tr>
<tr><td>☐Cyclosporine (Neoral, Sandimmune)</td><td></td><td></td><td></td></tr>
<tr><td>☐Acitretin (Soriatane)</td><td></td><td></td><td></td></tr>
<tr><td rowspan="6">☐Crohn's Disease</td><td colspan="4">Has the member tried and failed Corticosteroids? ☐Yes ☐No</td></tr>
<tr><td colspan="4">Please indicate if the member tried and failed any of the following for at least 3 months</td></tr>
<tr><td>Medication</td><td>Dates on Therapy</td><td>Dose</td><td>Reason for Discontinuing</td></tr>
<tr><td>☐Corticosteroids</td><td></td><td></td><td></td></tr>
<tr><td>☐Azathioprine (Imuran)</td><td></td><td></td><td></td></tr>
<tr><td>☐6-mercaptopurine (Purinethol)</td><td></td><td></td><td></td></tr>
<tr><td>☐Other:</td><td></td><td></td><td></td></tr>
<tr><td rowspan="7">☐ Ulcerative Colitis</td><td colspan="4">Has the member tried and failed Corticosteroids? ☐Yes ☐No</td></tr>
<tr><td colspan="4">Please indicate if the member tried and failed any of the following for at least 3 months</td></tr>
<tr><td>Medication</td><td>Dates on Therapy</td><td>Dose</td><td>Reason for Discontinuing</td></tr>
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<tr><td>☐Sulfasalzine (Azulfidine)</td><td></td><td></td><td></td></tr>
<tr><td>☐Mesalamine (Asacol)</td><td></td><td></td><td></td></tr>
<tr><td colspan="5">Please provide any additional information which should be considered in the space below:</td></tr>
<tr><td colspan="5"></td></tr>
<tr><td colspan="5"></td></tr>
</table>



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