



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
Remicade (Medicare Determination)**

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at 1-888-836-0730.
Please contact CVS|Caremark at 1-800-294-5979 with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Remicade (Medicare Determination).

Drug Name (select from list of drugs shown)
Remicade (infliximab)

Patient Information

Patient
Name: _____
Patient ID: _____
Patient
Group No.: _____
Patient
DOB: _____

Prescribing Physician

Physician
Name: _____
Physician
Phone: _____
Physician
Fax: _____
Physician
Address: _____
City, State,
Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each applicable question.

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|---|---|---|
| 1. Is the physician purchasing and providing the drug "incident to" physician services? | Y | N |
| 2. Does the patient have an active infection? | Y | N |
| 3. Does the patient have a diagnosis of moderate or severe congestive heart failure (CHF) [NYHA Class III or IV]? | Y | N |
| 4. Is the patient currently receiving, or has the patient in the past received Remicade therapy through a Caremark administered benefit?
[If the answer to this question is yes, may skip to question 6.] | Y | N |
| 5. Was the presence of tuberculosis (TB) ruled out (i.e., TB skin testing, etc) prior to initiation of this drug? | Y | N |
| 6. At the initiation of therapy, did the patient have the diagnosis of moderate or severe Crohn's disease as the reason for requesting Remicade?
[If the answer to this question is no, may skip to question 9.] | Y | N |
| 7. Did the patient have multiple draining enterocutaneous or rectovaginal fistulae when initially evaluated?
[If the answer to this question is yes, then skip to question 24.] | Y | N |



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| 8. Has patient tried and had an inadequate response to at least two first line agents for Crohn's disease such as prednisone, budesonide, Azulfidine (sulfasalazine), Imuran (azathioprine), Asacol or Pentasa (mesalamine)?
[May skip to question 24.] | Y | N |
| 9. At the initiation of therapy, did the patient have the diagnosis of active ankylosing spondylitis as the reason for requesting Remicade?
[If the answer to this question is no, then skip to question 14.] | Y | N |
| 10. Has the patient tried and had an inadequate response at least two non-steroidal anti-inflammatory drugs (NSAID), or has an intolerance to multiple NSAID drugs? [e.g., ibuprofen, diclofenac, naproxen, indomethacin, celecoxib, meloxicam]
[If the answer to this question is yes, then skip to question 12.] | Y | N |
| 11. Is the use of NSAIDs contraindicated in this patient? | Y | N |
| 12. Does the patient have predominantly peripheral arthritis symptoms?
[If the answer to this question is no, then skip to question 24.] | Y | N |
| 13. If indicated, did the patient have an inadequate response, or has an intolerance to or a contraindication to sulfasalazine?
[May skip to question 24.] | Y | N |
| 14. At the initiation of therapy, did the patient have the diagnosis of rheumatoid arthritis as the reason for requesting Remicade?
[If the answer to this question is no, may skip to question 17.] | Y | N |
| 15. Will the patient be prescribed Remicade in combination with methotrexate? | Y | N |
| 16. Has the patient tried and had an inadequate response to at least one or more disease-modifying anti-rheumatic drugs (DMARD) [e.g., methotrexate, Imuran (azathioprine), Ridaura (oral gold), Plaquenil (hydroxychloroquine) Cuprimine (D-penicillamine), Azulfidine (sulfasalazine), Arava (leflunomide)], or does the patient have an intolerance or contraindication to multiple DMARDs?
[May skip to question 24.] | Y | N |
| 17. At the initiation of therapy, did the patient have the diagnosis of active psoriatic arthritis as the reason for requesting Remicade?
[If the answer to this question is yes, may skip to question 24.] | Y | N |
| 18. At the initiation of therapy, did the patient have a diagnosis of chronic moderate to severe plaque psoriasis as the reason for requesting Remicade?
[If the answer to this question is no, may skip to question 21.] | Y | N |
| 19. Is the patient a candidate for systemic therapy or phototherapy? | Y | N |
| 20. Are systemic therapy or phototherapy medically less appropriate/effective or contraindicated for the patient?
[If the answer to this question is yes, may skip to question 24.] | Y | N |
| 21. At the initiation of therapy, did the patient have the diagnosis of moderately to severely active ulcerative colitis as the reason for requesting Remicade?
[If the answer to this question is no, no further questions required.] | Y | N |
| 22. Has the patient had an inadequate response to conventional therapy? (e.g., oral corticosteroids, 6-mercaptopurine (6-MP), azathioprine (AZA), aminosalicylates)
[If the answer to this question is no, no further questions required] | Y | N |
| 23. Is Remicade being prescribed to eliminate corticosteroid use? | Y | N |
| 24. Is the patient receiving a biologic response modifier, such as tumor necrosis factor (TNF) blocking agent other than Remicade [e.g., Cimzia, Enbrel, Humira], selective co-stimulation modulator | Y | N |



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(e.g., Orencia) interleukin-1 (IL-1) receptor antagonist [e.g., Kineret] or monoclonal antibody to B cells (e.g., Rituxan)?

[If the answer to this question is no, may skip to question 26.]

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|---|---|---|
| 25. Will the biologic response modifier be discontinued? | Y | N |
| 26. Has the prescriber assessed the patient's risk for hepatitis B, and if appropriate, tested for hepatitis B? | Y | N |

Comments: _____

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

Prescriber (Or Authorized) Signature and Date