

REMICADE (Non-Preferred)
PRIOR AUTHORIZATION FORM

Remicade is a Non-Preferred agent on the Medical Assistance Preferred Drug List (PDL). To review the prior authorization guidelines, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter-Cytokine & CAM Antagonists (accessible at: <http://www.dhs.state.pa.us/publications/bulletinsearch/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION

New Renewal Additional Information (PA#: _____)
pages in this request: _____ Office Contact Name: _____ Phone: (_____) _____

RECIPIENT INFORMATION

Name: _____ Recipient ID#: _____ Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Specialty: _____
NPI#: _____ OR MA Provider ID#: _____ State License#: _____
Prescriber Address: _____ Suite #: _____
City/State/Zip: _____ Phone: (_____) _____ Fax: (_____) _____
Long-term care facility (if applicable) contact name: _____ Phone: (_____) _____

MEDICAL INFORMATION

Dose: _____ Quantity: _____ Refills: _____ Currently receiving Remicade therapy

Weight (if weight-based dosing): _____ kg Diagnosis: _____ Diagnosis Code: _____ (Required)

Specialty Pharmacy Drug Program: Which Specialty pharmacy will be used? Diplomat Specialty Walgreens Specialty

Specialist Type: Dermatologist Gastroenterologist Rheumatologist Other: _____

Please check all that apply to the Recipient and submit documentation

- Screened for Tuberculosis Screened for Hepatitis B (antibody and/or surface antigen)
 Up-to-date with immunizations (If less than 21 years old, in accordance with EPSDT guidelines)

INITIAL REQUEST:

Ankylosing Spondylitis & Psoriatic Arthritis: Check all that apply to the Recipient and submit documentation

Tried & failed (or has a contraindication or intolerance to) any of the following:

- Enbrel Humira methotrexate Other DMARD: _____ Two NSAIDs: _____

Crohn's Disease & Ulcerative Colitis: Check all that apply to the Recipient and submit documentation

Tried & failed (or has a contraindication or intolerance to) any of the following:

- Humira Aminosalicylates Corticosteroids Immunomodulators

Plaque Psoriasis: Check all that apply to the Recipient and submit documentation

- At least 10% of the body surface area (BSA) is affected
 Less than 10% of the BSA is affected but involves critical areas of the body (face, palms, soles and/or genitals)
 Tried & failed (or has a contraindication or intolerance to) any of the following:
 PUVA UVB light with either coal tar or dithranol Enbrel Humira acitretin cyclosporine methotrexate

Rheumatoid Arthritis: Check all that apply to the Recipient and submit documentation

Tried & failed (or has a contraindication or intolerance to) any of the following:

- Enbrel Humira methotrexate Other DMARD: _____

Other Indications: Submit clinical documentation of diagnosis, supporting medical literature, and therapies that have been tried

ALL RENEWAL REQUESTS:

Please submit documentation of how Remicade has helped the Recipient's condition & level of functioning

PLEASE FAX COMPLETED FORM & SUPPORTING CLINICAL INFORMATION TO DHS – PHARMACY DIVISION

Prescriber Signature: _____ **Date:** _____

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