

- Preferred drug accepted. New verbal order authorized.
- Preferred drug rejected by physician.

Health New England

Medication Request Form (MRF)/Prescription Request

Remicade[®] (infliximab)

Prior Authorization

- Prior Authorization Only**
- Prior Authorization and Drug Delivery Request**

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Remicade[®]. Please complete this form and fax to ICORE Healthcare at (866)-364-2673. If you have any questions regarding this process, please contact ICORE Healthcare at (800) 775-5138.

J-code = J1745, 1 unit = 10mg

Medication Request Information (please complete each section of this form prior to transmittal):

Patient Information (all required)	Physician Information (all required)	
Patient Name:	Physician Name:	
Patient Cell Phone #: () -	Specialty:	
Patient HNE ID#:	NPI #:	
Patient Date of Birth:	HNE Provider #:	
Allergies:	DEA # :	
Diagnosis:	Telephone #: () -	
	Fax #: () -	
Drug Information		
Preferred Drug: <input type="checkbox"/> RA/Psoriasis – Enbrel/Humira <input type="checkbox"/> Crohn's – Humira		
Requested Drug/Strength/Form: Remicade		
Dose, Directions, and length of treatment (please be specific):	Quantity (per month):	Refills:
Physician Signature:	Date:	

Initial Authorization Indication:

- Treatment of moderate to severe Crohn's disease unresponsive to conventional therapy.
- Treatment of Rheumatoid Arthritis unresponsive to conventional therapy.
- Treatment of moderate to severe Ulcerative Colitis unresponsive to conventional therapy.
- Treatment of active Psoriasis unresponsive to conventional therapy.
- Treatment of active Psoriatic Arthritis unresponsive to conventional therapy
- Treatment of Ankylosing Spondylitis unresponsive to conventional therapy

Renewal Authorization Indication (Applies to Previously Approved Health New England Members):

- Treatment of moderate to severe Crohn's disease.
- Treatment of rheumatoid arthritis.
- Treatment of Ulcerative Colitis
- Treatment of Psoriasis
- Treatment of Psoriatic Arthritis
- Treatment of Ankylosing Spondylitis

Effective date: 5/31/2002, Date of Last Review 4/13/2010)

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Documentation of Medical Necessity (check all that apply):

- Infused therapy for RA should only be used if both Enbrel, Humira and Cimzia have failed.
- Remicade prescription is written by a gastroenterologist, rheumatologist, or dermatologist.
- Negative tuberculosis test.
- Patient does not have an active infection, including, but not limited to chronic or localized infection, histoplasmosis, tuberculosis, cytomegalovirus, HIV, or Hepatitis B?
- Crohn's Disease or Ulcerative Colitis - Patient has failed at least one (1) Immunomodulator (including but not limited to 6-mercaptopurine, azathioprine, corticosteroids or methotrexate).
- Rheumatoid Arthritis, Psoriatic arthritis or Ankylosing Spondylitis – Patient has failed treatment with Enbrel, Humira, and or Cimzia.
- Rheumatoid Arthritis, Psoriatic arthritis or Ankylosing Spondylitis - Patient will be receiving methotrexate in conjunction with Remicade.
- Rheumatoid Arthritis, Psoriatic arthritis or Ankylosing Spondylitis – Patient has failed at least one (1) Immunomodulator (including but not limited to azathioprene, hydroxychloroquine, cyclosporine).
- Psoriasis or Psoriatic Arthritis patient failed or have contraindication to at least two of the following: (PUVA, PUVB, methotrexate, cyclosporine, Acitretin, Enbrel, and Humira) **Circle treatments which have been tried**
- Patient does not have an allergy to murine proteins
- Patient does not have moderate to severe heart failure.
- Other pertinent history: