

Physician Remicade® Request Form



Non-Urgent Requests: Fax to (866) 533-5498

Urgent Requests: Fax to (866) 546-7972

To speak to a PerformRx representative: Call (866) 533-5490

*Note: Urgent requests should be reserved for those situations in which applying the standard procedure may seriously jeopardize the member's life, health, or ability to regain maximum functions.*

Form must be completed for processing.

Member Name: _____	Member ID#: _____
Address: _____	Apt # or Suite #: _____
City: _____ State: _____	Zip Code: _____
Phone #: _____ Height: _____ Weight: _____ lbs = _____ Kg	Birth Date: _____
Provider Name: _____	NPI/License #: _____
Address: _____	Apt # or Suite #: _____
City: _____ State: _____	Zip Code: _____
Contact Person: _____ Phone #: _____	Fax #: _____ E Mail: _____

Drug to be administered from (on): \_\_\_\_\_ to \_\_\_\_\_

Is the member currently residing in a Long-Term Care (LTC) facility? ( please check )  Yes  No

Has the member been evaluated for active or latent TB infection?  YES  NO Date of PPD (tuberculin skin test): \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Dose: \_\_\_\_\_ Sig: \_\_\_\_\_ ICD-9 Diagnosis Code: \_\_\_\_\_

For coverage determination for Remicade to treat Rheumatoid or Psoriatic Arthritis, additional information is needed to proceed with review. Prior to receiving approval for Remicade therapy, the member must have a documented medical reason to be unable to take therapeutic alternatives (see the table below of therapeutic alternatives). Please identify the therapies attempted and document the dose, start date, end date and reasons for discontinuation (e.g. intolerance, hypersensitivity, other medical reasons, etc.). If Remicade is ordered for non-fistulizing Crohn's disease, document in the Comments section the medical reason for not using oral conventional therapy for managing the member's non-fistulizing Crohn's disease.

> <input checked="" type="checkbox"/>	Drug	Dose	Start Date	End Date	Comments
<input type="checkbox"/>	Methotrexate (MTX)				
<input type="checkbox"/>	Triple Combo Therapy (Sulfasalazine, MTX, & Hydroxychloroquine)				
<input type="checkbox"/>	Leflunomide (Arava®)				
<input type="checkbox"/>	Etanercept (Enbrel®)*				
<input type="checkbox"/>	Anakinra (Kineret®)*				
<input type="checkbox"/>	Other ( )				

\* These medications require coverage determination and will only be approved when the member has a medical reason for not taking the oral therapeutic medications.

Additional Comments: \_\_\_\_\_