

# Physician Remicade® Request Form

Fax non-urgent requests to PerformRx Pharmacy Services at **866-369-6038** or urgent requests to **866-533-5491**. Urgent requests should be reserved for those situations in which applying the standard procedure may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. To speak to a representative, call **866-533-5490**. *Form must be completed for processing.*



Patient Name: \_\_\_\_\_ Plan ID#: \_\_\_\_\_  
 Address: \_\_\_\_\_ Apt # or Suite #: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs = \_\_\_\_\_ Kg Birth Date: \_\_\_\_\_

Physician Name: \_\_\_\_\_ License #: \_\_\_\_\_  
 Address: \_\_\_\_\_ Apt # or Suite #: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_  
 Physician Signature: \_\_\_\_\_

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

Is the member/patient 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 additional information is needed to proceed with review. Prior to receiving approval for Remicade therapy, the patient 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 disease, document in the Comments section the medical reason for not using oral conventional therapy for managing the patient's non-fistulizing Crohn 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 patient has a medical reason for not taking the oral therapeutic medications.

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