

Neighborhood Health Plan of Rhode Island Prior Authorization Form Remicade® (Infliximab)

Date of Request: _____

If approval criteria are met, Neighborhood Health Plan of Rhode Island will authorize coverage of Remicade® (Infliximab). Failure to fill out this form will result in a rejection of this medication at the pharmacy. Thank you for your assistance.

Please complete the following information:

Member Name: (required)	Member ID Number: (required) <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
Member Date of Birth: (required) / /	Member Sex: M F (Circle One)										
Prescriber Name: (required)	Contact Person at Office:										
Office Phone number: (required) () -	Office Fax Number: (required) () -										

Patient Weight _____ Dose and Directions for use _____
<p>INDICATIONS FOR USE: (check any that apply)</p> <ul style="list-style-type: none"> <input type="checkbox"/> For reduction in signs and symptoms and inhibition of the progression of structural damage in patients with moderately to severely active Rheumatoid Arthritis (RA), in combination with methotrexate. <input type="checkbox"/> For the reduction in signs and symptoms, achieving clinical remission and mucosal healing, and eliminating corticosteroid use in patients with moderately to severely active ulcerative colitis who have had an inadequate response to conventional therapy. <input type="checkbox"/> For reduction in signs and symptoms and inducing and maintaining remission in patients with moderately to severely active Crohn's disease who have had an inadequate response to conventional therapy <input type="checkbox"/> For reduction in the number of draining enterocutaneous and rectovaginal fistulas in patients with Crohn's disease <input type="checkbox"/> For the reduction of signs and symptoms in patients with active ankylosing spondylitis <input type="checkbox"/> For the reduction of signs and symptoms of active arthritis in patients with psoriatic arthritis <input type="checkbox"/> For the treatment of patients >18 with chronic severe plaque psoriasis <input type="checkbox"/> Other (please describe) _____ <p>CONTRAINDICATIONS: (check any that apply)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Moderate to severe heart failure (NYHA class III or IV) <input type="checkbox"/> Hypersensitivity to murine proteins <input type="checkbox"/> Hypersensitivity to any component of Remicade <p>PREVIOUS THERAPY:</p> <p>Has Patient had an unsatisfactory response to a previous trial of a conventional therapy including, but not limited to, agents such as disease modifying antirheumatic drugs (DMARDs) including methotrexate, alternate TNF agents, Metronidazole, Ciprofloxacin, mesalamine, prednisone, purinethol or phototherapy.</p> <ul style="list-style-type: none"> <input type="checkbox"/> NO <input type="checkbox"/> YES (please list previous therapies) <p>_____</p> <p>_____</p> <p>_____</p>
<ul style="list-style-type: none"> ▪ Patients should be evaluated for latent tuberculosis with a tuberculin skin test prior to infliximab therapy. Treatment of latent TB should be initiated before infliximab is used. ▪ Rare reactivation of hepatitis B has occurred in chronic virus carriers. ▪ Use caution in patients with pre-existing or recent-onset demyelinating CNS disorders.

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Prior Authorization Form
Remicade® (Infliximab)**

INITIAL APPROVAL WILL BE FOR 4 MONTHS AT WHICH TIME PATIENT SHOULD BE EVALUATED FOR RESPONSE TO THERAPY. IF PATIENT IS RESPONDING TO THERAPY, AN ADDITIONAL 9 MONTHS WILL BE APPROVED.

All information provided on this form is accurate as of this date.

Completed forms should be faxed to:

Customer Service Department

NHPRI

(866) 423-0945

Provider Signature: _____ **NPI:** _____ **Date:** _____

****Who is supplying the Remicade? The physician's office or a Pharmacy?**