FUTURE SCRIPTS Secure

Please complete ALL information below and fax your request to 1-888-671-5285

Inflectra® & Remicade® Coverage Determination Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:	Office Contact:	
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name: Select one of the following: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the Type of Coverage Determination Requested:

❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan.

Select the diagnosis below:

❑ Ankylosing spondylitis
❑ Crohn's disease
❑ Plaque psoriasis
❑ Polyarticular juvenile idiopathic arthritis
❑ Psoriatic arthritis
❑ Other diagnosis: _____

❑ Pulmonary sarcoidosis
❑ Pyoderma gangrenosum
❑ Rheumatoid arthritis
❑ Ulcerative colitis
❑ Wegener's granulomatosis

ICD-10 Code(s): _____

Clinical Information:

Will the patient receive concurrent therapy with other biologic disease modifying anti-rheumatic drugs (DMARDs) or other tumor necrosis factor antagonists? ❑ **Yes** ❑ **No**

Is there documentation the patient has been evaluated for active or latent tuberculosis (TB)? ❑ **Yes** ❑ **No**

For ankylosing spondylitis, also answer the following:

Does the patient have active, moderate to severe disease? ❑ **Yes** ❑ **No**

Is there documentation that the patient has had an inadequate response or inability to tolerate at least one other treatment such as NSAIDs, COX-2 inhibitors, or methotrexate? ❑ **Yes** ❑ **No**

For chronic pulmonary sarcoidosis, also answer the following:

Is there documentation that the patient has had history of trial and failure, or intolerance to a 3-month trial of corticosteroids and immunosuppressive agents? ❑ **Yes** ❑ **No**

For Crohn's disease, also answer the following:

Is there documentation that the patient has had an inadequate response or inability to tolerate at least one conventional treatment (e.g., corticosteroids, aminosalicylates, immunomodulators)? ❑ **Yes** ❑ **No**

For plaque psoriasis, also answer the following:

Does the patient have chronic, severe (i.e., extensive and/or disabling) disease? ❑ **Yes** ❑ **No**

Is the patient a candidate for systemic therapy? ❑ **Yes** ❑ **No**

Is there documentation that the patient has had an inadequate response or is unable to tolerate other systemic therapies? ❑ **Yes** ❑ **No**

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For polyarticular juvenile idiopathic arthritis, also answer the following:

Does the patient have evidence of active disease? ❑ **Yes** ❑ **No**

Is there documentation the patient has had failure or intolerance to a 3-month trial of an FDA-approved biologic disease modifying anti-rheumatic drug (DMARD)? ❑ **Yes** ❑ **No**

For psoriatic arthritis, also answer the following:

Does the patient have active disease? ❑ **Yes** ❑ **No**

Is there documentation that the patient has an inability to tolerate or inadequate response to at least one DMARD? ❑ **Yes** ❑ **No**

For rheumatoid arthritis, also answer the following:

Will the requested medication be used in combination with methotrexate? ❑ **Yes** ❑ **No**

If "no" to the above question, will the requested medication be used as monotherapy due to an intolerance or contraindication to methotrexate? ❑ **Yes** ❑ **No**

Is there documentation that the patient has had an inadequate response to any DMARD (e.g. sulfasalazine, azathioprine, cyclophosphamide, cyclosporine, methotrexate, and/or other anti-tumor necrosis factor agents)? ❑ **Yes** ❑ **No**

For ulcerative colitis, also answer the following:

Does the patient have moderate to severe disease? ❑ **Yes** ❑ **No**

Is there documentation that the patient has had an inadequate response or inability to tolerate at least one conventional treatment (e.g., corticosteroids, aminosalicylates, immunomodulators)? ❑ **Yes** ❑ **No**

For pediatric patients, also answer the following:

Does the patient have moderately to severely active disease? ❑ **Yes** ❑ **No**

Does the patient have documentation of an inadequate response to conventional therapies? ❑ **Yes** ❑ **No**

For Wegener's granulomatosis, also answer the following:

Does the patient have evidence of severe active disease? ❑ **Yes** ❑ **No**

Is there documentation that the patient has had an inadequate response or inability to tolerate corticosteroids and immunosuppressant agents? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.