FUTURE SCRIPTS

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

Inflectra®, Remicade® & Renflexis® Prior Authorization 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:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

- ❑ Active ankylosing spondylitis (AS)
- ❑ Active psoriatic arthritis (PsA)
- ❑ Chronic severe i.e., extensive and/or disabling) plaque psoriasis
- ❑ Fistulizing Crohn's disease
- ❑ Moderately to severely active Crohn's disease
- ❑ Moderately to severely active rheumatoid arthritis (RA)
- ❑ Moderately to severely active ulcerative colitis
- ❑ Sarcoidosis
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Select if the requested medication is prescribed by or in consultation with one of the following specialists, if applicable for the patient's diagnosis:

❑ Dermatologist ❑ Gastroenterologist ❑ Rheumatologist ❑ Pulmonologist

For Remicade requests only:

Has the patient had a trial and failure or intolerance to Inflectra and Renflexis? ❑ **Yes** ❑ **No**

For active ankylosing spondylitis (AS), also answer the following:

Has the patient had trial and failure, contraindication, or intolerance to two non-steroidal anti-inflammatory drugs (NSAIDs)? ❑ **Yes** ❑ **No**

For fistulizing Crohn's disease or moderately to severely active Crohn's disease, also answer the following:

Select if the patient has had trial and failure, contraindication, or intolerance to the following:

- ❑ 6-mercaptopurine (Purinethol)
- ❑ Azathioprine (Imuran)
- ❑ Corticosteroids (e.g., prednisone, methylprednisolone)
- ❑ Methotrexate (Rheumatrex, Trexall)

For moderately to severely active rheumatoid arthritis (RA), also answer the following:

Is the patient receiving concurrent therapy with methotrexate (Rheumatrex, Trexall)? ❑ **Yes** ❑ **No**

Has the patient had trial and failure, contraindication, or intolerance to methotrexate (Rheumatrex, Trexall)? ❑ **Yes** ❑ **No**

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For moderately to severely active ulcerative colitis, also answer the following:

Select if the patient has had trial and failure, contraindication, or intolerance to the following conventional therapies:

- ❑ 6-mercaptopurine (Purinethol)
- ❑ Aminosalicylate (e.g., mesalamine [Asacol, Pentasa, Rowasa], olsalazine [Dipentum], sulfasalazine [Azulfidine, Sulfazine])
- ❑ Azathioprine (Imuran)
- ❑ Corticosteroids (e.g., prednisone, methylprednisolone)

For Remicade requests only:

Does the patient have pediatric ulcerative colitis? ❑ **Yes** ❑ **No**

For sarcoidosis, also answer the following:

Has the patient had trial and failure, contraindication, or intolerance to corticosteroids (e.g., prednisone)? ❑ **Yes** ❑ **No**

Has the patient had trial and failure, contraindication, or intolerance to one immunosuppressant (e.g., methotrexate [Rheumatrex, Trexall], Cytoxan [cyclophosphamide], or Imuran [azathioprine])? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following question:

Is there documentation the patient has had a positive clinical response to infliximab therapy? ❑ **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.

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