

REMICADE (MEDICARE DETERMINATION)

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross[®] BlueShield[®] of South Carolina

Patient Information	
Name:	Insurance ID #:
Group #:	Birthdate:

Provider Information	
Physician's Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

When this form is complete, please fax to Caremark at 888-836-0730.

This fax machine is in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 800-294-5979 with any questions concerning prior authorization procedures.

1. Is the physician purchasing and providing the drug "incident to" physician services? Y N
2. Has the patient previously received Remicade through a CVS Caremark administered benefit?
[If the answer this question is no, skip to question 4.] Y N
3. Has the patient responded to Remicade therapy (e.g., condition improved or stabilized)?
[If the answer to this question is yes, skip to question 22.]
[If the answer to this question is no, no further questions are required.] Y N
4. Prior to initiating therapy, does the patient have a diagnosis of moderately to severely active RA as the reason to request Remicade?
[If the answer to this question is no, skip to question 7.] Y N
5. Will Remicade be used in combination with MTX or is there a clinical reason not to use MTX??
[If the answer to this question is no, no further questions are required.] Y N

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6. Did the patient inadequately respond to a nonbiologic DMARD or does the patient have an intolerance or contraindication to at least two nonbiologic DMARDs?
• Examples of nonbiologic DMARDs: MTX, leflunomide, hydroxychloroquine, sulfasalazine
[If the answer to this question is yes, skip to question 17.]
[If the answer to this question is no, no further questions are required.] Y N
7. Prior to initiating therapy, does the patient have a diagnosis of active psoriatic arthritis as the reason to request Remicade?
[If the answer to this question is yes, skip to question 17.] Y N
8. Prior to initiating therapy, does the patient have a diagnosis of active ankylosing spondylitis as the reason to request Remicade?
[If the answer to this question is no, skip to question 10.] Y N
9. Did the patient inadequately respond to two NSAIDs, or does the patient have an intolerance or contraindication to at least two NSAIDs?
[If the answer to this question is yes, skip to question 17.]
[If the answer to this question is no, no further questions are required.] Y N
10. Prior to initiating therapy, does the patient have the diagnosis of chronic severe plaque psoriasis (sufficiently severe to consider systemic therapy or other systemic therapies medically less appropriate) as the reason to request Remicade?
[If the answer to this question is yes, skip to question 17.] Y N
11. Prior to initiating therapy, does the patient have a diagnosis of fistulizing Crohn's disease as the reason to request Remicade?
[If the answer to this question is yes, skip to question 17.] Y N
12. At the initiation of therapy, does the patient have a diagnosis of moderately to severely active Crohn's disease as the reason to request Remicade?
[If the answer to this question is no, skip to question 14.] Y N
13. Did the patient inadequately respond to one conventional therapy or biologic, or does the patient have a contraindication or intolerance to at least two conventional therapies?
• Examples of conventional therapies are corticosteroids, sulfasalazine, azathioprine or mesalamine. Previous biologic use may include Humira or Cimzia.
[If the answer to this question is yes, skip to question 17.] Y N
14. Prior to initiating therapy, did the patient have a diagnosis of moderately to severely active ulcerative colitis as the reason to request Remicade?
[If the answer to this question is no, skip to question 16.] Y N
15. Did the patient inadequately respond to one conventional therapy (e.g., oral corticosteroids, 6-mercaptopurinem azathioprine, aminosalicylates) or does the patient have a contraindication or intolerance to at least two conventional therapies? Y N
16. Prior to initiating therapy, does the patient have one of the following diagnoses as the reason to request Remicade? Accepted compendial uses:
• Hidradentis suppurativa
• JIA/JRA, refractory to other DMARDs
• Inflammatory bowel disease arthritis
• Pyoderma gangrenosum, in patients with Crohn's disease or ulcerative colitis
• Reactive arthritis
• Uveitis
• Wegener's granulomatosis
[If the answer to this question is no, no further questions are required.] Y N

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17. Prior to initiating therapy, was the patient screened for latent TB infection with either a TB skin test or interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB)?
[If the answer to this question is no, no further questions are required.] Y N
18. Was the result of the TB test positive?
[If the answer to this question is no, skip to question 21.] Y N
19. Does the patient have active TB?
[If the answer to this question is yes, no further questions are required.] Y N
20. Is the patient receiving treatment for latent TB infection or has the patient completed treatment for latent TB infection prior to initiating Remicade?
[If the answer to this question is yes, no further questions are required] Y N
21. Prior to starting therapy, has the prescriber assessed the patient's risk of hepatitis B, and if appropriate ruled out or initiated treatment for hepatitis B?
[If the answer to this question is no, no further questions are required.] Y N
22. Does the patient have unstable moderate or severe heart failure (NYHA Class III or IV)? Y N
23. Prior to treatment with Remicade, or to continue treatment with Remicade, will the use of any other biologic agent be discontinued?
• Examples are: Cimzia, Enbrel, Humira, Kineret, Orencia, Rituxan, Simponi or Tysabri Y N
24. Does the patient have an active infection (chronic or localized)? Y N

Comments: _____

Information on this form is accurate as of the date below.

Prescriber's Signature: 	Date:
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