Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Remicade (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-844-242-0908**.
When conditions are met, we will authorize the coverage of Remicade (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Remicade (infliximab)

Other, please specify_____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

1. Has this plan authorized Remicade in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 5.]

2. Does the patient have a diagnosis of ulcerative colitis or Crohn's? Y N

   [If no, skip to question 4.]

3. Is the patient in remission without requiring more than 5mg of prednisone daily? Y N

   [If no, then no further questions.]

[If yes, skip to question 54.]

4. Has the patient had at least a 20% improvement in symptoms? Y N

   [If no, then no further questions.]

   [If yes, skip to question 54.]

5. Does the patient have a diagnosis of rheumatoid arthritis (RA) with moderate to high disease activity? Y N

   [If no, skip to question 8.]

6. Has the patient had failure to an adequate trial (3 months) of two disease modifying anti-rheumatic drugs (DMARDs) regimens (one must be methotrexate)? Y N

   If yes, list medications tried: _____

   Note: Monotherapy regimen: methotrexate (MTX), hydroxychloroquine (HCQ), leflunomide (LEF), sulfasalazine (SSZ).

   Combination regimen: MTX+SSZ+HCQ; MTX+HCQ, MTX+LEF, MTX+SSZ, SSZ+HCQ

   [If yes, skip to question 46.]

7. Does the patient have a contraindication to methotrexate? Y N

   Note: Contraindications such as Pregnancy, alcoholism, Chronic liver disease, Leukopenia, thrombocytopenia, or anemia.

   If yes, please document contraindication:_____

   [If no, then no further questions]

   [If yes, skip to question 46.]

8. Does the patient have a diagnosis of ankylosing spondylitis (AS)? Y N

   [If no, skip to question 12.]

9. Does the patient have unacceptable disease activity despite an adequate trial (3 months) with at least 2 different NSAIDs? Y N

   If yes, please list medications tried:_____

   [If no, skip to question 11.]

10. Is the patient currently on or will continue taking an NSAID with the requested medication? Y N

    [If yes, skip to question 46.]

11. Does the patient have contraindications to NSAIDs? Y N

    Note: Contraindications such as true allergic reaction to NSAIDs, history of worsening asthma symptoms after taking aspirin or NSAIDs, current GI bleed, severe renal dysfunction.

    If yes, please document contraindication:_____

    [If yes, then skip to question 46.]

    [If no, then no further questions.]

12. Does the patient have a diagnosis of plaque psoriasis? Y N

    [If no, skip to question 19.]

13. Does the patient have more than 10% of body surface area involvement with plaque psoriasis or has a PASI score of more than 10? Y N

    [If no, then no further question.]

14. Does the plaque psoriasis have a significant impact on physical, psychological, or social wellbeing? Y N

    [If no, then no further questions.]

15. Has the patient failed standard topical therapies? Y N

    If yes, please list medications tried: _____

    [If no, then no further questions.]

16. Has the patient tried and had an insufficient response to phototherapy (UVB or PUVA) or is unable to receive phototherapy? Y N

    If yes, please provide rationale:_____

    [If no, then no further questions.]

17. Has the patient had failure to an adequate trial (3 months) of methotrexate or cyclosporine? Y N

[If yes, then skip to question 46.]

18. Does the patient have a contraindication to both methotrexate and cyclosporine? Y N

    Note: Contraindications such as Pregnancy, alcoholism, Chronic liver disease, Leukopenia, thrombocytopenia, or anemia.

    If yes, please document contraindications: _____

    [If yes, then skip to question 46.]

    [If no, then no further questions.]

19. Does the patient have a diagnosis of psoriatic arthritis (PsA)? Y N

    [If no, skip to question 28.]

20. Does the patient have primarily axial disease (involving the spine) or active enthesitis/dactylitis? Y N

    [If no, skip to question 22.]

21. Has the patient tried an adequate trial (3 months) with at least 2 different NSAIDs and had inadequate response? Y N

    If yes, please list medications tried:_____

    [If yes, skip to question 26.]

    [If no, skip to question 27.]

22. Does the patient have active psoriatic arthritis? Y N

    [If no, then no further questions.]

23. Has the patient had failure to an adequate trial (3 months) of methotrexate? Y N

    [If yes, skip to question 26.]

24. Does the patient have a contraindication to methotrexate? Y N

    Note: Contraindications such as Pregnancy, alcoholism, Chronic liver disease, Leukopenia, thrombocytopenia, or anemia.

    If yes, please document contraindication:_____

    [If no, then no further questions.]

25. Has the patient had failure to an adequate trial (3 months) of sulfasalazine or leflunomide? Y N

    [If no, then no further questions.]

26. Is the patient currently on or will continue taking an NSAID with requested medication? Y N

    [If yes, then skip to question 46.]

27. Does the patient have contraindications to NSAIDs? Y N

    Note: Contraindications such as true allergic reaction to NSAIDs, history of worsening asthma symptoms after taking aspirin or NSAIDs, current GI bleed, severe renal dysfunction.

    If yes, please document contraindication:_____

    [If yes, then skip to question 46.]

    [If no, then no further questions.]

28. Does the patient have a diagnosis of Crohn's Disease? Y N

    [If no, skip to question 34.]

29. Has the patient had inadequate response or intolerable side effects to IV corticosteroids after 7-10 days or oral prednisone (dosed at 40mg or more per day) for 30 days)? Y N

    [If yes, skip to question 33.]

30. Does the patient have steroid-dependent Crohn's disease as evidenced by one of the following: A) Patient had a relapse within three months of stopping corticosteroids; OR B) Patient is unable to taper steroids to an acceptable dose after 3 months without having symptom recurrence? Y N

    [If no, then no further questions.]

31. Has the patient had failure to an adequate trial (3 months) of azathioprine (AZA), mercaptopurine (6-mp) or injectable methotrexate? Y N

    [If yes, skip to question 33.]

32. Does the patient have a contraindication to all of the following: azathioprine (AZA), injectable methotrexate and mercaptopurine (6-mp)? Y N

If yes, please document contraindication(s): _____

[If no, then no further questions]

33. Is the patient at least 6 years of age? Y N

[If no, then no further questions.]

[If yes, skip to question 45.]

34. Does the patient have a diagnosis of ulcerative colitis (UC)? Y N

[If no, then no further questions.]

35. Has the patient had inadequate response or intolerable side effects to IV corticosteroids after 7-10 days or oral prednisone (dosed at 40mg or more per day for 30 days)? Y N

[If no, skip to question 40.]

36. Has the patient had a previous treatment failure with azathioprine (AZA) AND mercaptopurine (6-MP) OR has a contraindication to azathioprine and mercaptopurine? Y N

If yes, please list medication tried and/or contraindications:_____

[If yes, skip to question 43.]

37. Has the patient had surgery for ulcerative colitis (UC)? Y N

[If yes, skip to question 43.]

38. Has the patient had an inadequate response or intolerable side effects to cyclosporine? Y N

[If yes, skip to question 43.]

39. Does the patient have a contraindication to cyclosporine? Y N

[If no, then no further questions.]

[If yes, skip to question 43.]

40. Does the patient have steroid-dependent ulcerative colitis as evidenced by one of the following: A) Patient had a relapse within three months of stopping corticosteroids; OR B) Patient is unable to taper steroids to an acceptable dose after 3 months without having symptom recurrence? Y N

[If no, then no further questions.]

41. Has the patient had failure to an adequate trial (3 months) of azathioprine (AZA) or mercaptopurine (6-MP)? Y N

[If yes, skip to question 43.]

42. Does the patient have a contraindication to azathioprine and mercaptopurine? Y N

[If no, then no further questions]

43. Is the patient at least 18 years of age? Y N

[If yes, skip to question 45.]

44. Is the patient at least 6 years of age? Y N

[If no, then no further questions.]

[If yes, skip to question 48.]

45. Has the patient tried and failed Humira? Y N

[If yes, skip to question 48.]

[If no, then no further questions.]

46. Has the patient tried and failed BOTH Enbrel and Humira? Y N

[If no, then no further questions.]

47. Is the patient at least 18 years of age? Y N

[If no, then no further questions.]

48. Is Remicade being prescribed by, or in consultation with a specialist, based on indication (rheumatologist, dermatologist, or gastroenterologist)? Y N

[If no, then no further questions.]

49. Has the patient been screened for latent tuberculosis (TB) and hepatitis B? Y N

[If no, then no further questions.]

50. Does the patient have an active infection (including Hepatitis B and/or tuberculosis (TB)? Y N

[If no, skip to question 52.]

51. Is the patient currently receiving or has completed treatment for latent TB infection or Hepatitis B? Y N

    [If no, then no further questions.]

52. Will Remicade be given in combination with another biologic DMARD? Y N

    [If yes, then no further questions.]

53. Does the patient have CHF (NYHA class III or IV)? Y N

    [If yes, then no further questions.]

54. Is the prescribed dose within the FDA-approved dosing (based on weight)? Y N

    Please document current weight:

    _____

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date