05/02/2014

Prior Authorization Form

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Remicade (IL88)

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 Medicaid at **1-855-684-5250.**
Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Remicade (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

## Drug Name (select from list of drugs shown)

Remicade (infliximab)

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: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

**Diagnosis:** _____ **ICD Code:** _____

**Please circle the appropriate answer for each question.**

1. Is Remicade prescribed for an FDA approved indication? Y N
   If yes, please indicate diagnosis

   [If no, no further questions.]

2. Will the patient be concurrently receiving live vaccines, other TNF-inhibitors or Kineret? Y N

   [If yes, no further questions.]

3. Has Aetna Better Health authorized this medication in the past for this patient (i.e., previous authorization is on file under Aetna Better Health)? Y N

   [If no, skip to question 5.]

4. Is the patient responding to Remicade therapy? Y N

   [No further questions.]

5. Initial Authorization: Fistulizing Crohn's Disease Does the patient meet ALL of the following? Y N

   Diagnosis is Fistulizing Crohn's Disease \ Treatment is prescribed by, or in consultation with a gastroenterologist \ Patient is 18 years of age, or older

   [If yes, no further questions.]

6. Initial Authorization: Crohn's Disease Does the patient meet ALL of the following? Y N

   Diagnosis is moderate to severe active Crohn's Disease (CD) \ Treatment is prescribed by, or in consultation with a gastroenterologist \ Patient is 6 years of age, or older

   [If no, skip to question 10.]

7. Does the patient meet ONE of the following? Please indicate which of the below apply to patient (if patient has contraindication/intolerance to corticosteroids, list contraindication/intolerance) Y N

   Trial and failure of a compliant regimen of oral corticosteroids (for moderate to severe CD) or intravenous corticosteroids (for severe and fulminant CD) for one month OR \ Documented contraindication or intolerance to PO or IV corticosteroids

   [If no, no further questions.]

8. Does the patient meet ONE of the following? Please indicate which of the below apply to patient (if patient has contraindication/intolerance to azathioprine or mercaptopurine, list contraindication/intolerance): Y N

   [If the answer to this question is no, then no further questions are required.]

9. Does the patient meet ONE of the following? Please indicate which of the below apply to patient (if patient has contraindication/intolerance to Humira, list contraindication/intolerance): Y N

Trial and failure of a compliant regimen of Humira for 3 consecutive months OR \ Documented contraindication or intolerance to Humira.

[No further questions.]

10. Initial Authorization: Ulcerative Colitis Does the patient meet ALL of the following? Y N

    Diagnosis is moderate to severe active Ulcerative Colitis \ Treatment is prescribed by, or in consultation with a gastroenterologist \ Patient is 18 years of age, or older

    [If no, skip to question 15.]

11. Does the patient meet ONE of the following? Please indicate which of the below apply to patient (if patient has contraindication/intolerance to aminosalicylates, list contraindication/intolerance): Y N

    Trial and failure of a compliant regimen of oral or rectal aminosalicylates (i.e., sulfasalazine or mesalamine) for 2 consecutive months OR \ Documented contraindication or intolerance to aminosalicylates.

    [If no, no further questions.]

12. Does the patient meet ONE of the following? Please indicate which of the below apply to patient (if patient has contraindication/intolerance to corticosteroids, list contraindication/intolerance): Y N

    Trial and failure of a compliant regimen of oral or intravenous corticosteroid therapy for 1 month OR \ Documented contraindication or intolerance to PO or IV corticosteroids.

    [If no, no further questions.]

13. Does the patient meet ONE of the following? Please indicate which of the below apply to patient (if patient has contraindication/intolerance to azathioprine or mercaptopurine, list contraindication/intolerance): Y N

    Trial and failure of a compliant regimen of azathioprine or mercaptopurine for 3 consecutive months OR \ Documented contraindication or intolerance to azathioprine or mercaptopurine.

    [If no, no further questions.]

14. Has the patient had a trial and failure of a compliant regimen of Humira for at least 2 months? Y N

    [No further questions.]

15. Initial Authorization: Rheumatoid Arthritis (RA) Does the patient meet ALL of the following? Y N

    Diagnosis is moderate to severe rheumatoid arthritis \ Treatment is prescribed by, or in consultation with a rheumatologist \ Patient is 18 years of age, or older

    [If no, skip to question 19.]

16. Does the patient meet ONE of the following? Please indicate which of the below apply to patient (if patient has contraindication to methotrexate, list contraindication): Y N

    Remicade will be given in combination with methotrexate OR \ Documented contraindication or intolerance to methotrexate.

    [If no, no further questions.]

17. Has patient met ONE of the following? Please indicate which of the below apply to patient (if patient has contraindication/intolerance to methotrexate and other DMARDs, list drugs and contraindications/intolerance): Y N

    Trial and failure of a compliant regimen of methotrexate in combination with hydroxychloroquine, leflunomide or sulfasalazine for at least 3 months OR \ Trial and failure of monotherapy with methotrexate for at least 3 months and trial and failure of monotherapy with hydroxychloroquine, leflunomide or sulfasalazine for at least 3 months OR \ Patient has a contraindication or intolerance to methotrexate and other DMARDs.

    [If no, no further questions.]

18. Does the patient meet ONE of the following? Please indicate which of the below apply to patient (if patient has contraindication/intolerance to Enbrel and Humira, list contraindication/intolerance): Y N

    Trial and failure of a compliant regimen of Enbrel or Humira for 3 months OR \ Documented contraindication or intolerance to Enbrel and Humira.

    [No further questions.]

19. Initial Authorization: Ankylosing Spondylitis Does the patient meet ALL of the following? Y N

    Diagnosis is Ankylosing Spondylitis \ Treatment is prescribed by, or in consultation with a rheumatologist \ Patient is 18 years of age, or older

    [If no, skip to question 22.]

20. Does the patient meet ONE of the following? Please indicate which of the below apply to patient (if patient has contraindication/intolerance to NSAIDs, list contraindication/intolerance): Y N

    Trial and failure of a compliant regimen of two formulary NSAIDs within the last 60 days OR \ Documented contraindication or intolerance to NSAIDs.

    [If no, no further questions.]

21. Does the patient meet ONE of the following? Please indicate which of the below apply to patient (if patient has contraindication/intolerance to Enbrel and Humira, list contraindication/intolernace): Y N

    Trial and failure of a compliant regimen of Enbrel or Humira for 3 consecutive months OR \ Documented contraindication or intolerance to Enbrel and Humira.

    [No further questions.]

22. Initial Authorization: Plaque Psoriasis Does the patient meet ALL of the following? Y N

    Diagnosis is chronic severe Plaque Psoriasis \ Treatment is prescribed by, or in consultation with a dermatologist \ Patient is 18 years of age, or older

    [If no, skip to question 27.]

23. Does the patient have an affected area of at least 5% of body surface area (BSA) OR involvement of critical areas (palms, soles, genitals or face) that interferes with daily activities? Y N

    [If no, no further questions.]

24. Does the patient meet ONE of the following? Please indicate which of the below apply to patient (if patient has contraindication to UVB and PUVA, list contraindication): Y N

    Trial and failure of UVB or PUVA ,OR \ Documented contraindication to UVB and PUVA

    [If no, no further questions.]

25. Does the patient meet ONE of the following? Please indicate which of the below apply to patient (if patient has contraindication to methotrexate, list contraindication): Y N

    Trial and failure of a compliant regimen of methotrexate for 3 consecutive months, OR \ Patient has a contraindication to use of methotrexate.

26. Does the patient meet ONE of the following? Please indicate which of the below apply to patient (if patient has contraindication/intolerance to Enbrel and Humira, list contraindication/intolerance): Y N

    Trial and failure of a compliant regimen of Enbrel or Humira for 3 consecutive months OR \ Documented contraindication or intolerance to Enbrel and Humira.

    [No further questions.]

27. Initial Authorization: Psoriatic Arthritis Does the patient meet ALL of the following? Y N

    [If the answer to this question is no, then no further questions are required.]

    [If no, no further questions.]

28. Does the patient meet ONE of the following? Please indicate which of the below apply to patient (if patient has contraindication/intolerance to methotrexate, list contraindication/intolerance): Y N

    Trial and failure of a compliant regimen of methotrexate for at least 3 months OR \ Documented contraindication or intolerance to methotrexate.

    [If no, no further questions.]

29. Does the patient meet ONE of the following? Please indicate which of the below apply to patient (if patient has contraindication/intolerance to Enbrel and Humira, list contraindication/intolerance): Y N

Trial and failure of a compliant regimen of Enbrel or Humira for 3 months OR \ Documented contraindication or intolerance to Enbrel and Humira.

[No further questions.]

**Comments:**

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

**Prescriber (Or Authorized) Signature** **Date**