03/17/2016

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS FAMILY HEALTH PLAN (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 **1-844-242-0908**.
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: _____

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 56.]

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 56.]

5. Does the patient have a diagnosis of EARLY rheumatoid arthritis (RA) (defined as disease duration less than 6 months) WITH high disease activity and poor prognostic factors (i.e., functional limitation, extra-articular disease, bony erosions on radiograph, or positive rheumatoid factor or anti-CCP antibodies)? If yes, submit labs and progress notes to support or document here. Y N

   _____

   [If yes, skip to question 29.]

6. Does the patient have a diagnosis of established RA with moderate to high disease activity? Y N

   [If no, skip to question 9.]

7. Has the patient failed a 3-month minimum trial of methotrexate AND at least 1 other oral DMARD (sulfasalazine, leflunomide, or hydroxychloroquine)? If yes, list medication regimens tried including dose and duration. Y N

   _____

   (Note: hydroxychloroquine used alone is not considered an adequate therapy)

   [If yes, skip to question 29.]

8. Does the patient have any of the following contraindications to methotrexate: Pregnancy \ Alcoholism \ Chronic liver disease \ Leukopenia, thrombocytopenia, or significant anemia? If yes, please indicate which contraindication(s). Y N

   _____

   [If no, then no further questions]

   [If yes, skip to question 29.]

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

   [If no, skip to question 15.]

10. Is the patient currently taking an NSAID (e.g., ibuprofen, naproxen, etodolac, meloxicam, indomethacin)? Y N

    [If yes, skip to question 12.]

11. Does the patient have any of the following contraindications to NSAIDs: True allergic reaction to NSAIDs \ History of worsening asthma symptoms after taking aspirin or NSAIDs \ Current GI bleed \ Severe renal dysfunction. If yes, please indicate which contraindication(s). Y N

    _____

    [If no, then no further questions]

12. Does the patient have peripheral joint disease? Y N

    [If yes, skip to question 14.]

13. Does the patient have primarily axial disease (involving the spine)? Y N

    [If yes, skip to question 28.]

    [If no, then no further questions.]

14. Has the patient failed an adequate 3-month minimum trial of sulfasalazine or does the patient have a sulfa allergy? Y N

    [If yes, skip to question 29.]

    [If no, then no further questions.]

15. Does the patient have a diagnosis of severe and extensive plaque psoriasis (i.e., more than 10% of body surface area is affected OR patient has a PASI score of more than 10)? Y N

    [If no, skip to question 20.]

16. Has the patient failed standard topical therapies? List topical therapies tried. Y N

    _____

    [If no, then no further questions]

17. Does the patient meet one of the following: Trial and failure of phototherapy (UVB or PUVA) \ Patient has contraindication to UVB and PUVA \ Psoriasis rapidly relapsed after previous phototherapy was stopped (i.e., more than 50% worsening of disease within 3 months). Please indicate which applies (if patient has contraindication to UVB and PUVA, list contraindication). Y N

_____

[If no, then no further questions]

18. Has the patient failed an adequate 3-month minimum trial of methotrexate or cyclosporine? Y N

[If no, then no further questions.]

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

[If no, then no further questions.]

[If yes, skip to question 29.]

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

[If no, skip to question 30.]

21. Is the patient currently taking an NSAID (e.g., ibuprofen, naproxen, etodolac, meloxicam, indomethacin)? Y N

[If yes, skip to question 23.]

22. Does the patient have any of the following contraindications to NSAIDs: True allergic reaction to NSAIDs \ History of worsening asthma symptoms after taking aspirin or NSAIDs \ Current GI bleed \ Severe renal dysfunction. If yes, please indicate which contraindication(s). Y N

_____

[If no, then no further questions]

23. Does the patient have peripheral joint involvement? Y N

[If yes, skip to question 25.]

24. Does the patient have primarily axial disease (involving the spine)? Y N

[If yes, skip to question 28.]

[If no, then no further questions.]

25. Has the patient failed an adequate 3-month minimum trial of methotrexate? Y N

[If yes, skip to question 29.]

26. Does the patient have any of the following contraindications to methotrexate: Pregnancy \ Alcoholism \ Chronic liver disease \ Leukopenia, thrombocytopenia, or significant anemia? If yes, please indicate which contraindication(s). Y N

_____

[If no, then no further questions]

27. Has the patient failed an adequate 3-month minimum trial of sulfasalazine or leflunomide? Y N

[If yes, skip to question 29.]

[If no, then no further questions.]

28. Has the patient failed an adequate 3-month trial of TWO different NSAIDs (e.g., ibuprofen, naproxen, etodolac, meloxicam, indomethacin)? List NSAIDs tried. Y N

_____

[If no, then no further questions]

29. Has the patient had a trial and failure of BOTH Enbrel and Humira? Y N

[If no, then no further questions.]

[If yes, skip to question 50.]

30. Does the patient have a diagnosis of Crohns Disease? Y N

[If no, skip to question 38.]

31. Is the patient failing to respond to IV corticosteroids after 7-10 days? Y N

[If yes, skip to question 37.]

32. Is the patient steroid-dependent as evidenced by ONE of the following:Crohns disease relapsed within three months of stopping corticosteroids \ Patient requires prednisone equivalent of at least 10mg/day to prevent relapse \ For CHILDREN/ADOLESCENTS: Patient has required daily low dose prednisone for at least 4 months to prevent relapse Y N

33. Has the patient failed an adequate 3-month minimum trial of azathioprine or mercaptopurine? Y N

[If yes, skip to question 37.]

34. Does the patient have a contraindication to azathioprine and mercaptopurine? If yes, please indicate which contraindication(s): Y N

_____

[If no, then no further questions.]

35. Has the patient failed an adequate 3-month trial of injectable methotrexate? Y N

[If yes, skip to question 37.]

36. Does the patient have any of the following contraindications to methotrexate: Pregnancy \ Alcoholism \ Chronic liver disease \ Leukopenia, thrombocytopenia, or significant anemia? If yes, please indicate which contraindication(s): Y N

_____

[If no, then no further questions.]

37. Has the patient had a trial and failure of Humira? Y N

[If no, then no further questions.]

[If no, skip to question 49.]

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

[If no, then no further questions.]

39. Is the patient failing to respond to IV corticosteroids after 7-10 days? Y N

[If no, skip to question 43.]

40. Has the patient had a previous treatment failure with azathioprine AND mercaptopurine OR has the patient already had surgery for UC? Y N

[If yes, skip to question 47.]

41. Is the patient a poor surgical candidate or refusing surgery AND has had an inadequate response to cyclosporine? Y N

[If yes, skip to question 47.]

42. Does the patient have a contraindication to cyclosporine? List contraindication(s) if applicable: Y N

_____

[If no, then no further questions.]

[If yes, skip to question 47.]

43. Is the patient steroid-dependent as evidenced by ONE of the following:Colitis relapsed within three months of stopping corticosteroids \ Patient requires prednisone equivalent of at least 10mg/day to prevent relapse \ For CHILDREN/ADOLESCENTS: Patient has required daily low dose prednisone for at least 4 months to prevent relapse Y N

[If no, then no further questions.]

44. Has the patient failed an adequate 3-month minimum trial of azathioprine or mercaptopurine? Y N

[If yes, skip to question 47.]

45. Does the patient have a contraindication to azathioprine and mercaptopurine? If yes, please indicate which contraindication(s): Y N

_____

[If no, then no further questions.]

46. Has the patient failed an adequate 3-month trial of sulfasalazine (at least 4g/day), mesalamine (at least 4.8g/day), or balsalazide (at least 6.75g/day)? Y N

[If no, then no further questions.]

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

[If no, skip to question 49.]

48. Has the patient had a trial and failure of Humira? Y N

[If no, then no further questions.]

[If yes, skip to question 51.]

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

[If no, then no further questions.]

[If yes, skip to question 51.]

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

[If no, then no further questions.]

51. 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.]

52. Is the patient up to date on all recommended vaccinations? Y N

[If no, then no further questions.]

53. Has the patient been screened for latent tuberculosis and hepatitis B? Y N

[If no, then no further questions.]

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

[If yes, then no further questions.]

55. Does the patient have any of the following: NYHA class III or IV CHF \ Untreated chronic hepatitis B \ Chronic hepatitis B on treatment but with Child-Pugh class B or C \ Chronic hepatitis C infection with severe liver disease or Child Pugh Class B or C Y N

[If yes, then no further questions.]

56. Is Remicade being prescribed at an FDA-approved dose based on the indication? Document dose (in mg per kg) and patient's weight. Y N

(Note: requests without documented weight will not be approved.)

Comments:

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

Prescriber (Or Authorized) Signature Date