

# Drug Coverage Review Request

## Remicade®



### SUPPLY ALL PRESCRIBER AND PATIENT INFORMATION

#### PATIENT

MD First Name \_\_\_\_\_  
MD Last Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Zip Code \_\_\_\_\_  
Phone \_\_\_\_\_  
Fax \_\_\_\_\_  
DEA number (optional) \_\_\_\_\_

#### PATIENT

Cardholder ID # \_\_\_\_\_  
Patient Last Name \_\_\_\_\_  
Patient First Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Zip Code \_\_\_\_\_  
Phone \_\_\_\_\_

Your patient's benefit plan requires that we review certain requests for coverage with the prescribing physician. This includes requests for benefit coverage beyond plan specifications. Please complete the following questions and then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the benefit plan's rules.

### SECTION A

Please answer the following questions

- Yes  No Will the patient be receiving MORE THAN ONE biologic rheumatoid arthritis agent (*Enbrel, Kineret, Humira, Remicade, Orencia or Rituxan*) AT THE SAME TIME?
- For which indication is this drug being prescribed? (please choose one primary indication)
  - Moderate to severe rheumatoid arthritis (RA)
  - Psoriatic arthritis (PsA)
  - Rapidly advancing, progressive RA
  - Moderate to severe Crohn's disease
  - Fistulizing Crohn's disease
  - Ankylosing spondylitis\*\*\* ^ **please answer questions 3-4**
  - Moderate to severe ulcerative colitis
  - Mild ulcerative colitis\*\*\*\* ^ **please answer questions 5-6**
  - Severe plaque psoriasis (that is, affecting more than 10% of the patient's body surface area)
  - Other
- Yes  No Has the patient experienced INADEQUATE SYMPTOM RELIEF from other drug therapies such as NSAIDS, COX-2 inhibitors, or methotrexate?
- Yes  No **IF NO TO QUESTION 3**, is the patient UNABLE TO RECEIVE NSAIDS, COX-2 inhibitors, or methotrexate?
- Yes  No Has the patient experienced an INADEQUATE RESPONSE with conventional therapies such as aminosalicylates, corticosteroids, or immunosuppressants?
- Yes  No **IF NO TO QUESTION 5**, is the patient UNABLE TO RECEIVE drug therapy with conventional therapies such as aminosalicylates, corticosteroids, or immunosuppressants?

### SECTION B

Physician Signature

PHYSICIAN SIGNATURE

DATE

**FAX COMPLETED FORM TO: 1 800 837-0959**

PLEASE DO NOT FAX WITH A COVER SHEET



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