



Physician Remicade® Request Form

Fax non-urgent requests to PerformRx Pharmacy Services at **877-693-8280** or urgent requests to **877-693-8476**. Urgent requests should be reserved for situations in which the standard procedure may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. To speak to a representative, call **800-578-0898**. *Form must be completed for processing*

Patient Name: _____ Plan ID#: _____
 Address: _____ Apt # or Suite #: _____
 City: _____ State: _____ Zip Code: _____
 Phone #: _____ Weight: _____ lbs = _____ Kg Birth Date: _____

Physician Name: _____ NPI #: _____
 Address: _____ Apt # or Suite #: _____
 City: _____ State: _____ Zip Code: _____
 Contact Person: _____ Phone #: _____ Fax #: _____

Physician Signature: _____ LTC member Yes No, Date Admitted _____

Drug to be administered from (on): _____ to _____ Or was administered on: _____ to be replaced to physician's office.

Has the member been evaluated for active or latent TB infection? YES NO Date of PPD (tuberculin skin test): _____
 Diagnosis: _____ Dose: _____ Sig: _____ ICD-9 Diagnosis Code: _____

For prior authorization for Remicade additional information is needed to proceed with review. Prior to receiving approval for Remicade therapy, the patient must have a documented medical reason to be unable to take the preferred medications (see the table below of preferred alternatives). Please identify the therapies attempted and document the dose, start date, end date and reasons for discontinuation (e.g. intolerance, hypersensitivity, other medical reasons). If Remicade is ordered for non-fistulizing Crohn disease, document in additional comments section the medical reason for not using oral conventional therapy for managing the members non-fistulizing Crohn disease.

<input checked="" type="checkbox"/>	Drug	Dose	Start Date	End Date	Comments
<input type="checkbox"/>	Methotrexate (MTX)				
<input type="checkbox"/>	Triple Combo Therapy (Sulfasalazine, MTX, & Hydroxychlorpquine)				
<input type="checkbox"/>	Leflunomide (Arava®)				
<input type="checkbox"/>	Etanercept (Enbrel®)*				
<input type="checkbox"/>	Adalimumab (Humira®)*				
<input type="checkbox"/>	Other ()				

* These medications require prior authorization and will only be approved when the patient has a medical reason for not taking the oral formulary medications.

AdditionalComments: _____