



**PRIOR AUTHORIZATION REQUEST FORM**

EOC ID:

**Remicade® (infliximab)**

**Phone: 215-991-4300 Fax back to: 866-240-3712**

HEALTH PARTNERS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please print clearly.**

<b>Patient Name:</b> Member Number: Date of Birth: Group Number: Address: City, State, Zip:	<b>Physician Name:</b> Fax: Phone: Office Contact: NPI: State Lic. Id: Address: City, State, Zip:
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Drug Name: Expedited/Urgent

Directions:

<b>Please answer the following questions and sign below:</b>
Q1. What is the patient's diagnosis? Rheumatoid Arthritis Active or fistulizing Crohn's disease Psoriatic arthritis Plaque psoriasis Ankylosing spondylitis Ulcerative colitis Other
Q2. If OTHER, please specify:
Q3. For rheumatoid arthritis/ankylosing spondylitis/psoriatic arthritis; has the patient tried and failed or is the patient intolerant to at least one DMARD? Yes No
Q4. For Active or fistulizing Crohn's disease or Ulcerative colitis; has the patient tried and failed or is the patient intolerant to at least one corticosteroid? Yes No
Q5. For Active or fistulizing Crohn's disease or Ulcerative colitis: Has the patient tried and failed or is the patient intolerant to at least one of the following: sulfasalazine (Azulfidine) or mesalazine (Asacol, Pentasa)? Yes No
Q6. For Crohn's Disease; has the patient tried and failed or is the patient intolerant to at least one of the following: azathioprine (Imuran), 6-mercaptopurine (Purinethol) or methotrexate? Yes No
Q7. For Plaque Psoriasis; Does the patient have greater than 10% of the body involvement? Yes No
Q8. For Plaque Psoriasis; has the patient failed or had inadequate response to a trial of Methotrexate?



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**Patient Name:**

**Physician Name:**

Yes	No
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**Physician Signature**

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**Date**

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