CHORUS COMMUNITY HEALTH PLANS

Prior Authorization Form: **Remicade**

If this is an urgent request, please call Chorus Community Health Plans Pharmacy Services.
Otherwise, please return completed form – Phone: 844-201-4677 or Fax: 844-201-4675

| *Please type or print neatly. Incomplete responses may delay this request.* | | | |
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| Office Contact: | | Provider Specialty: | |
| Provider First Name: | | Provider Last Name: | |
| Provider Phone #: | | Provider Fax #: | Provider NPI #: |
| Patient Name: | CCHP Member ID #: | Patient DOB: | Patient Age: |
| Drug Requested:<br>**Brand** **Generic** | Strength: | Frequency: | Quantity Dispensed (including units): |

**Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.**

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| **New medication**<br>**Ongoing medication** | If ongoing, please provide start date: | If ongoing, did the member show improvement while on therapy? | **Yes**<br>**No** |
| Diagnosis: | | Date of Diagnosis: | |
| Please indicate place of administration/ infusion:<br>☐ Physician's Office ☐ Hospital/Facility ☐ Patient Home<br>Please provide facility/provider name and address:<br>_____<br>_____ | | Please indicate how medication will be billed:<br>Billed directly by the provider via JCODE Provide JCODE: _____<br>Billed by a pharmacy and delivered to the provider<br>Billed by a pharmacy and delivered to the patient | |

**Please complete the following questions for all diagnoses.**

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| Please indicate disease severity: ☐ Mild ☐ Moderate ☐ Severe | |
| Is there evidence of infection? ☐ Yes ☐ No | |
| Date of PPD (tuberculin) test: | Result of PPD test: ☐ Positive ☐ Negative |
| Is the member currently using another TNF-blocking agent or biologic agent in combination with Remicade? ☐ Yes ☐ No<br>If yes, please indicate drug name: | |

**Please indicate the diagnosis on the left and complete the corresponding questions.**

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| **Rheumatoid Arthritis** | Has the member tried and failed Methotrexate for at least 3 months? ☐ Yes ☐ No |
| | Please provide dates of therapy and dose: |
| | Reason for discontinuation: |
| | Please indicate if the member tried and failed any of the following for at least 3 months?<br>☐ Leflunomide (Arava) ☐ Minocycline<br>☐ Sulfasalazine (Azulfidine) ☐ Hydroxychloroquine (Plaquenil) |

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| | Please provide dates of therapy and dose: |
| | Reason for discontinuation: |
| **Ankylosing Spondylitis** | Does the member have dominant peripheral disease? ☐ Yes ☐ No |
| | Does the member have dominant axial disease? ☐ Yes ☐ No |
| | Please indicate if the member tried and failed any of the following for at least 3 months?<br>☐ Methotrexate ☐ Sulfasalazine (Azulfidine)<br><br>Please provide dates of therapy and dose:<br><br>Reason for discontinuation: |
| | Has the member tried and failed any NSAIDs for at least 3 months? ☐ Yes ☐ No<br>If yes, please indicate drug name(s):<br><br>Please provide dates of therapy and dose:<br><br>Reason for discontinuation: |
| **Psoriatic Arthritis** | Does the member have dominant peripheral disease? ☐ Yes ☐ No |
| | Does the member have dominant axial disease? ☐ Yes ☐ No |
| | Please indicate if the member tried and failed any of the following for at least 3 months?<br>☐ Methotrexate ☐ Cyclosporine (Neoral)<br>☐ Sulfasalazine (Azulfidine) ☐ Leflunomide( Arava)<br><br>Please provide dates of therapy and dose:<br><br>Reason for discontinuation: |
| | Has the member tried and failed any NSAIDs for at least 3 months? ☐ Yes ☐ No<br>If yes, please indicate drug name(s):<br><br>Please provide dates of therapy and dose:<br><br>Reason for discontinuation: |
| **Plaque Psoriasis** | Please indicate body surface area (BSA) involvement:<br>☐ Less than 10% ☐ Greater than or equal to 10% |
| | Does the member have psoriasis on the palms, soles, head, neck, or genitalia? ☐ Yes ☐ No |

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| | Has the member tried and failed topical treatments? ☐ Yes ☐ No<br>If yes, indicate drug name(s):<br><br>Reason for discontinuation: |
| | Has the member tried phototherapy or photochemotherapy? ☐ Yes ☐ No |
| | Please indicate if the member tried and failed any of the following for at least 3 months?<br>☐ Methotrexate ☐ Cyclosporine (Neoral, Sandimmune) ☐ Acitretin (Soriatane)<br><br>Please provide dates of therapy and dose:<br><br>Reason for discontinuation: |
| **Crohn's Disease** | Has the member tried and failed corticosteroids? ☐ Yes ☐ No<br>If yes, please provide dates of therapy and dose:<br><br>Reason for discontinuation: |
| | Please indicate if the member tried and failed any of the following for at least 3 months?<br>☐ Azathioprine (Imuran) ☐ 6-mercaptopurine (Purinethol)<br>Other, Please list drug name: _____<br><br>Please provide dates of therapy and dose:<br><br>Reason for discontinuation: |
| **Ulcerative Colitis** | Has the member tried and failed corticosteroids? ☐ Yes ☐ No<br>If yes, please provide dates of therapy and dose:<br><br>Reason for discontinuation: |
| | Please indicate if the member tried and failed any of the following for at least 3 months?<br>☐ Sulfasalzine (Azulfidine) ☐ Mesalamine (Asacol) ☐ 6-mercaptopurine (Purinethol)<br>Other, Please list drug name: _____<br><br>Please provide dates of therapy and dose:<br><br>Reason for discontinuation: |