PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Remicade (infliximab)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department 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 note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. What diagnosis is this drug being prescribed for (select ALL that apply)?

- ☐ Ankylosing Spondylitis
- ☐ Crohn's Disease
- ☐ Plaque Psoriasis
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Ulcerative Colitis
- ☐ Acute Graft-Versus-Host Disease
- ☐ Adult Onset Still's Disease
- ☐ Arthropathy in Inflammatory Disease
- ☐ Behcet's Syndrome
- ☐ Early Synovitis in Rheumatoid Arthritis
- ☐ Hidradenitis Suppurativa
- ☐ Juvenile Idiopathic Arthritis
- ☐ Kawasaki Disease
- ☐ Pyoderma Gangrenosum
- ☐ Reiter's Disease
- ☐ SAPHO Syndrome

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- ☐ Sarcoidosis
- ☐ Takayasu's Disease
- ☐ Uveitis
- ☐ Uveitis in Behcet's Syndrome
- ☐ Wegener's Granulomatosis
- ☐ Other

Q2. Select the regimen being requested.

- ☐ 5 mg/kg every 6 weeks
- ☐ 3 mg/kg every 8 weeks
- ☐ 5 mg/kg every 8 weeks
- ☐ 10 mg/kg every 8 weeks
- ☐ Other (please specify)

Q3. Provide ICD code(s) for diagnosis.

Q4. Please indicate location of administration.

- ☐ Home
- ☐ Physician office (drug from office stock - buy and bill) DOES NOT REQUIRE PRIOR AUTHORIZATION
- ☐ Physician office (MEMBER to obtain drug from PHARMACY with a prescription)
- ☐ Other

Q5. What is the patient's weight?

Q6. Is this a new start for this patient? If not, please specify start date.

☐ Yes ☐ No

Q7. Additional Comments

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Prescriber Signature _____ Date _____

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.