



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.

Form with fields for Patient Name, Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Prescriber Name, Supervising Physician, Fax, Office Contact, NPI, Address, City, State ZIP, Specialty/facility name, and State Lic ID.

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)?

- Checkboxes for various medical conditions: 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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Patient Name:	Prescriber Name:
	Supervising Physician:
<input type="checkbox"/> Sarcoidosis <input type="checkbox"/> Takayasu's Disease <input type="checkbox"/> Uveitis <input type="checkbox"/> Uveitis in Behcet's Syndrome <input type="checkbox"/> Wegener's Granulomatosis <input type="checkbox"/> Other	
Q2. Select the regimen being requested. <input type="checkbox"/> 5 mg/kg every 6 weeks <input type="checkbox"/> 3 mg/kg every 8 weeks <input type="checkbox"/> 5 mg/kg every 8 weeks <input type="checkbox"/> 10 mg/kg every 8 weeks <input type="checkbox"/> Other (please specify)	
Q3. Provide ICD code(s) for diagnosis.	
Q4. Please indicate location of administration. <input type="checkbox"/> Home <input type="checkbox"/> Physician office (drug from office stock) <input type="checkbox"/> Physician office (MEMBER to obtain drug from PHARMACY with a prescription)	
Q5. What is the patient's weight?	
Q6. Is this a new start for this patient? If not, please specify start date. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. Additional Comments	



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Patient Name:	Prescriber Name: Supervising Physician:
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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.

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