



Prescription Drug Coverage Determination Form
Tumor Necrosis Factor Inhibitor
Remicade® (infliximab)

Please fax the completed form to Mercy Health Plans' Pharmacy Department at 314-214-8201 or 1-800-466-9854.

Patient Information

Patient Name: Date of Birth:
Subscriber ID#:
Address City State Zip Code

Physician Information

Name: Specialty: Tax ID#:
Office Address City State Zip Code
Telephone: Fax: Contact Person

Physician Signature (REQUIRED): Date

Medication Information (requests for non-formulary agents will be considered for members having a documented failure or contraindication to preferred agents.)

Medication name: J-code:
Dose: Directions:
Expected Duration of Therapy:

Prior Authorization Criteria:

- 1. Is the medication being requested to treat an FDA-approved indication not otherwise excluded from Part D?
2. Does the patient have an active infection?
3. Does the patient have moderate to severe (NYHA Class III or IV) congestive heart failure?
4. Was the patient evaluated for latent tuberculosis infection with a PPD tuberculin test?
5. Does the patient have a diagnosis of Crohn's disease?

6. Does the patient have a diagnosis of ankylosing spondylitis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes:		
▪ Has the patient had an inadequate response to at least 2 non-steroidal anti-inflammatory (NSAID) drugs or intolerance to multiple NSAIDs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
▪ Does the patient have a contraindication to NSAIDs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Does the patient have a diagnosis of rheumatoid arthritis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes:		
▪ Will the patient be prescribed methotrexate in combination with Remicade®?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
▪ Has the patient demonstrated an inadequate response to at least 1 disease-modifying anti-rheumatoid drug (DMARD) [e.g., methotrexate (MTX), Imuran (azathioprine), Ridaura (oral gold), Plaquenil (hydroxychloroquine), Cuprimine (D-penicillamine), Azulfidine (sulfasalazine), or Arava (leflunomide)] or intolerance to multiple DMARDs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Does the patient have or has ever had a diagnosis of psoriasis or does the patient <u>not</u> have a diagnosis of psoriasis, but has symptoms consistent with a diagnosis of psoriatic arthritis (i.e. oligoarthritis, dactylitis, enthesitis, distal interphalangeal joint involvement, nail dystrophy)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes:		
▪ Is the patient a candidate for systemic therapy or phototherapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Does the patient have a diagnosis of moderately to severely active ulcerative colitis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes:		
▪ Has the patient demonstrated an inadequate response to conventional therapy (e.g. oral or rectal 5-ASA products or glucocorticosteroids)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Does the patient have a diagnosis of chronic inflammatory bowel disease arthritis (IBDA)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes:		
▪ Has the patient demonstrated inadequate response to at least 2 first-line agents such as sulfasalazine, azathioprine, 6-mercaptopurine, MTX, or oral steroids?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Does the patient have a diagnosis of active reactive arthritis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes:		
▪ Has the patient demonstrated an inadequate response to at least 2 first-line agents such as NSAIDs or DMARDs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. Has the patient been assessed for risk of active hepatitis B infection?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please provide any additional history or medical information that may support coverage (attach office notes as necessary): _____

Note: If approved coverage will be as specified in above criteria or through the end of the year (December 31, 20xx). Some medications may be subject to quantity limitations or restricted to certain pharmacies.