

**Specialty Medication Review Program**

Please allow 3 business days for review of this request

If you are supplying the medication directly, complete form and fax to:

➤ **Specialty Review Unit**  
Fax: 1-800-306-0188  
Phone: 1-800-306-0151

If you need to order the medication, please complete and fax this form to one of the following specialty pharmacies:

➤ **Accredo Health**  
Fax: 1-800-216-5044  
Phone: 1-888-239-9139

➤ **CuraScript Pharmacy**  
Fax: 1-888-773-7386  
Phone: 1-866-297-0930

➤ **OptionCare Specialty Pharmacy**  
Fax: 1-866-435-2173  
Phone: 1-866-435-2171

Please complete all of the following Patient/Physician information:

Patient Name: (Please Print)		Patient Phone #: (with area code)	
Patient ID #:		Patient Birthdate:	
MD Name:		MD Specialty:	
MD Address:			
MD Provider Number:		MD Phone #:	
MD DEA #:	NPI#:	MD FAX #:	
Location of Infusion: <input type="checkbox"/> MD office <input type="checkbox"/> Outpatient facility: _____ <input type="checkbox"/> Other: _____			
Medication Shipping Address:			

REMICADE	Dosage and Directions:	Qty:	# Refills:	Patient weight:
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**QUESTIONS / INDICATIONS FOR MEDICAL NECESSITY - for diagnosis of:**

<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Ankylosing Spondylitis	<input type="checkbox"/> Psoriatic Arthritis	<input type="checkbox"/> Crohn's Disease
<input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> Chronic Severe Plaque Psoriasis	<input type="checkbox"/> Other	
<b>Rheumatoid Arthritis: Initial dosage 3mg/kg at weeks 0,2,6 &amp; every 8 weeks thereafter. Max 5 infusions in 6 mos</b>			<b>Yes</b> <b>No</b>
1. Is patient being treated by a Rheumatologist?			
2. Does patient meet the ACR criteria for diagnosis of RA?			
3. Has patient had a trial of Methotrexate 12.5mg – 15mg for at least 12 weeks?			
4. List current dosage and duration of Methotrexate? _____			
<b>Ankylosing Spondylitis: Dosage of 5mg/kg at weeks 0,2,6 and every 6 weeks thereafter</b>			<b>Yes</b> <b>No</b>
1. Is this patient being treated by a Rheumatologist?			
2. Does patient have diagnosis of Ankylosing Spondylitis established by an expert?			
3. Has patient had a trial of at least 2 different NSAIDs for at least 1 month? List all NSAIDs, dosages and duration of use: 1) _____ 2) _____			
<b>Psoriatic Arthritis: Dosage of 5mg/kg at weeks 0,2,6 and ever 8 weeks thereafter</b>			<b>Yes</b> <b>No</b>
1. Has this patient's diagnosis of psoriatic arthritis been established by a Dermatologist or Rheumatologist?			
2. Has this patient had an adequate trial & failure of an NSAID or DMARD? (List)			
<b>Chronic Severe Plaque Psoriasis: Dosage of 5mg/kg at weeks 0,2,6 and every 8 weeks thereafter</b>			<b>Yes</b> <b>No</b>
1. Is this patient being treated by a Dermatologist?			
2. Does the patient have active moderate to severe chronic plaque psoriasis % BSA _____			
3. Has the patient had treatment failure to first line drug therapy after a trial of at least 3 months? Please indicate which drug(s) he/she has not responded to: <input type="checkbox"/> Acitretin <input type="checkbox"/> Methotrexate <input type="checkbox"/> Cyclosporine <input type="checkbox"/> Medium / High Potency Steroids <input type="checkbox"/> Anthralin, Calcipotriene, or Tazarotene <input type="checkbox"/> UVB & Coal Tar or PUVA & Topical Corticosteroids <input type="checkbox"/> Intralesional Corticosteroid Injections			
<b>Crohn's Disease: ACUTE Initial dosage 5mg/kg weeks 0,2,6 &amp; every 8 weeks thereafter. Max 4 infusions in 4 mos</b>			<b>Yes</b> <b>No</b>
1. Is diagnosis moderate to severe active Crohn's disease or fistulizing Crohn's disease?			
2. Is patient currently experiencing disease flare?			
3. Has patient had failure or intolerance with at least one agent from two drug classes listed below? <input type="checkbox"/> corticosteroids (i.e., prednisone) <input type="checkbox"/> aminosaliclates (i.e., sulfasalazine, mesalamine) <input type="checkbox"/> antibiotics (i.e., metronidazole, quinolones)			
<b>Crohn's Disease: MAINTENANCE Continued therapy 5mg/kg every 8 weeks. Max 7 infusions in 1 yr after initial 4 mos</b>			<b>Yes</b> <b>No</b>
1. Is diagnosis moderate to severe active Crohn's disease or fistulizing Crohn's disease?			
2. Has patient tried and failed one of the following azathioprine, mercaptopurine, or methotrexate?			
3. Is patient steroid dependant?			
<b>Ulcerative Colitis: Dosage of 5mg/kg at 0,2,6 weeks and every 8 weeks thereafter</b>			<b>Yes</b> <b>No</b>
1. Has the diagnosis of Ulcerative Colitis been made by a Gastroenterologist?			
2. Has the patient had failure or intolerance to at least 2 different agent s listed below <input type="checkbox"/> Thiopurines (azathioprine, mercaptopurine) <input type="checkbox"/> IV or oral steroids <input type="checkbox"/> 5-Aminosaliclates (sulfasalazine, mesalamine, olsalazine) <input type="checkbox"/> Cyclosporine			

**Other Comments/Justification:** \_\_\_\_\_

I certify that the above information is true and accurate to the best of my knowledge.

Prescriber signature \_\_\_\_\_ Date \_\_\_\_\_