

Remicade® (Infliximab)

Prior Authorization Request (Physician to Complete)



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Visit www.wellmark.com for the Wellmark Drug List for current medication tier levels and updated PA Forms

Facsimile Transmittal Sheet

Date: ____/____/____

To: Wellmark Pharmacy Services

From (Prescriber's Name): _____

Fax Number: (866) 884-4345

Prescriber's DEA Number: _____

Phone Number: (800) 600-8065

Prescriber's Phone Number: _____

Prescriber's Specialty: _____

Prescriber's Fax Number: _____

Prescriber's Office Address: _____
Street Suite # City State Zip

Patient Name: _____

Patient ID: _____ Patient DOB: ____/____/____

Please answer the following questions and fax this form back to (866) 884-4345. All fields are REQUIRED.

Is this a request for initial therapy or continuation of therapy? _____

1. Does the patient have one of the following diagnoses? **Please complete all corresponding questions**

Ankylosing spondylitis Adult Moderately to severely active Crohn's Disease

Pediatric Crohn's Disease Moderately to severely active Ulcerative Colitis:

Adult, chronic severe plaque psoriasis: duration > 6 months? Yes No

Does the patient have moderate to severe psoriasis affecting at least 10% of the patient's body surface area (BSA) or psoriasis affecting the hands, feet, face, or genitals? Yes No

Active psoriatic arthritis: Does the patient have at least 3 swollen/tender joints? Yes No

Does the patient have plaque psoriasis with a target lesion \geq 2cm in diameter? Yes No

Adult rheumatoid arthritis, moderately to severely active

2. Prescribers specialty: _____

3. Has the patient been evaluated for active and latent tuberculosis? Yes No

4. Has the patient shown inadequate response to any of the following topical therapies? Yes No (check all that apply)

anthralin coal tar glucocorticoids Dovonex (calcipotriene) Tazorac (tazarotene)

contraindication: _____

5. Has the patient shown inadequate response any of the following systemic therapies? Yes No (check all that apply)

glucocorticoids methotrexate non-steroidal anti-inflammatory drugs (NSAID's) sulfasalazine

Soriatane (acitretin) azathioprine cyclosporine UVB/PUVA phototherapy 6-mercaptopurine

leflunomide cyclosporine methotrexate UVB/PUVA phototherapy d-penicillamine gold

hydroxychloroquine contraindication: _____

6. Does the patient have any of the poor prognostic factors for **rheumatoid arthritis** listed below? Yes No

Functional limitation Extraarticular disease Rheumatoid Factor positive (RF+) RA Lung disease

Felty's syndrome RA Vasculitis Secondary Sjogren's syndrome rheumatoid nodules

Bony erosions by radiography Positive anti-cyclic citrullinated peptide antibodies (anti-CCP)

7. Has the patient had inadequate response to one of the following TNF blockers? Yes No (check all that apply)

Cimzia (certolizumab) Enbrel (etanercept) Humira (adalimumab) Simponi (golimumab)

Kineret (anakinra)

contraindication: _____

8. Dose per injection: _____ mg Frequency of injection: _____ per _____

Attach lab results and other documentation as necessary

Printed Name _____

Signature _____

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