



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 1-800-647-2240.

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. Does the patient have an active infection? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Does the patient have moderate to severe (NYHA Class III or IV) congestive heart failure? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Was the patient evaluated for latent tuberculosis infection with a PPD tuberculin test? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes: | | |
| ▪ Did the patient have a positive PPD tuberculin test? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ▪ If yes, is the patient being treated for latent tuberculosis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Has the patient been assessed for risk of active hepatitis B infection? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Does the patient have a diagnosis of Crohn's disease? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes: | | |
| ▪ Did the patient have multiple draining enterocutaneous or rectovaginal fistulae? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ▪ Has the patient demonstrated an inadequate response at least 2 of the following first-line therapies (i.e., prednisone, budesonide, sulfasalazine (Azulfidine), azathioprine (Imuran), or mesalamine (Asacol or Pentasa)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Does the patient have a diagnosis of moderately to severely active ulcerative colitis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

<p>If yes:</p> <ul style="list-style-type: none"> ▪ Has the patient demonstrated an inadequate response to conventional therapy (i.e. oral or rectal 5-ASA products or glucocorticosteroids)? 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>7. Does the patient have a diagnosis of chronic inflammatory bowel disease arthritis (IBDA)?</p> <p>If yes:</p> <ul style="list-style-type: none"> ▪ Is the patient refractory to standard therapies for IBDA (e.g. NSAIDs, sulfasalazine, or azathioprine)? 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
<p>8. Does the patient have a diagnosis of rheumatoid arthritis?</p> <p>If yes:</p> <ul style="list-style-type: none"> ▪ Will the patient be prescribed methotrexate in combination with Remicade®? ▪ 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 <input type="checkbox"/> Yes <input type="checkbox"/> No
<p>9. Does the patient have a diagnosis of ankylosing spondylitis?</p> <p>If yes:</p> <ul style="list-style-type: none"> ▪ Has the patient had an inadequate response to at least 2 non-steroidal anti-inflammatory (NSAID) drugs or intolerance to multiple NSAIDs? ▪ Does the patient have a contraindication to NSAIDs? ▪ Is the ankylosing spondylitis predominately peripheral arthritis? ▪ Has the patient demonstrated an inadequate response, intolerance to, or contraindication to sulfasalazine? 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
<p>10. Does the patient have or has ever had a diagnosis of psoriasis?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>11. 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)?</p> <p>If yes:</p> <ul style="list-style-type: none"> ▪ Is the patient a candidate for systemic therapy or phototherapy? 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
<p>12. Does the patient have a diagnosis of chronic severe (i.e. extensive and/or disabling) plaque psoriasis?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>13. Does the patient have a diagnosis of active reactive arthritis?</p> <p>If yes:</p> <ul style="list-style-type: none"> ▪ 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 <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.