



Remicade (infliximab) FCHP Pharmacy Prior Authorization Form

Please fax the completed form to **1-508-791-5101**. For urgent situations, please call **1-866-275-3247** and select **option 5**. Services are subject to coverage, benefit, network and contract policies and exclusions.

Patient information:

Last name: _____ First name: _____ M.I.: _____
DOB: _____ FCHP ID #: _____

Physician information:

Physician name: _____ Specialty: _____
Phone: _____ Fax: _____
Signature: _____ Date: _____

Remicade Infusion:

Dose (mg/kg): _____ Frequency: _____
Length of therapy: _____
Patient weight: _____ (indicate kg or lbs) Date of this weight _____

Indication:

- Ankylosing Spondylitis (720.0)
- Crohn's Disease (555.9)
- Fistulating Crohn's Disease (569.81)
- Plaque Psoriasis (696.1)
- Psoriatic Arthritis (696.0)
- Rheumatoid Arthritis (714.0)
- Ulcerative Colitis (556.9)

Medications or treatments previously used:

Name of medication	Reason for failure	Date attempted
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has the patient tried and failed any of the following? (Check all that apply)

- at least one corticosteroid
- mesalamine (Asacol, Pentasa)
- methotrexate
- olsalazine (Dipentum)
- adalimumab (Humira)
- balsalazide (Colazal)
- etanercept (Enbrel)
- azathioprine (Imuran)
- sulfasalazine (Azulfindine)
- 6-mercaptopurine (Purinethol)

Reason why patient cannot use FCHP-preferred medications (formulary available at fchp.org)

Will medication be administered to the patient at home by Home Solutions? Yes No

If no, please explain why the patient cannot receive Remicade at home: _____
