



Date of Request: \_\_\_\_\_

### Sterling Retiree Rx Prior Authorization Form

#### REMICADE (Infliximab) IV Injection

##### Coverage Criteria

**Rheumatoid Arthritis** - patient must demonstrate inadequate response to at least 1 DMARD or intolerance to 2 DMARDs; Remicade is to be used in combination with methotrexate.

**Crohn's Disease** - patient must demonstrate an inadequate response to at least 2 first-line agents unless the patient has multiple draining enterocutaneous or rectovaginal fistulae.

**Ulcerative Colitis** - patient must demonstrate an inadequate response to at least 2 first-line agents such as oral or rectal 5-ASA products or glucocorticosteroids.

**Ankylosing Spondylitis** - patient must demonstrate inadequate response to at least 2 NSAIDs or intolerance to 2 NSAIDs. If the ankylosing spondylitis is predominantly peripheral arthritis, patient must demonstrate an inadequate response or intolerance to sulfasalazine only.

**Psoriasis** - patient must be a candidate for systemic therapy or phototherapy.

**Reactive Arthritis** - patient must demonstrate inadequate response to at least 2 first-line agents such as NSAIDs, or DMARDs.

**Inflammatory Bowel Disease Arthritis** - patient must demonstrate an inadequate response to at least 2 first-line agents such as sulfasalazine, azathioprine, 6-mercaptopurine, MTX or oral steroids.

##### Required Medical Information

Patient must be evaluated for latent TB with a PPD test. Patient must also be assessed for the risk of hepatitis B and, if appropriate, be tested.

##### Exclusion Criteria

Patients are excluded if they have an active infection or moderate to severe CHF.

Member Information					
Name					
Enrollment/Card-holder ID Number					
Group/Plan		Male		Female	
Date of Birth		Age		Weight in Kg	
Street Address					
City		State		Zip	

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**Sterling Retiree Rx Prior Authorization Form**

**Drug Name**

**Date**

Physician Information					
Name					
Agent		Contact Name			
Specialty/Office					
Clinic Name					
Street Address					
City		State		Zip	
Phone		Fax			
Requested Drug					
REMICADE	Reason for Request				
Condition/Diagnosis Related					
Clinical Drug/Lab History Pertinent to Request					
Labs: Baseline/Ongoing			Strength/Dosage		
Formulary Alternative(s) Attempted?			Yes:		No:
Please List Alternative Formulary Drugs					
Comments					

Physician's Signature: \_\_\_\_\_ Fax Form to 1-877-847-9904