

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

Remicade (infliximab) for Crohn's Disease

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF

MEDICAL NECESSITY TO 855-828-4992 note the new fax number

CRITERIA:

- Age requirement: 6 years old and older
- Diagnosis of moderate to severely active Crohn's Disease
- Has failed conventional therapy (i.e. 5-aminosalicylates, antibiotics, MTX, 6-mercaptopurine, azathioprine, corticosteroids, budesonide)
- Negative TB skin test within the previous 12 months or history of treatment for latent TB infection
- Absence of active bacterial or viral infection, malignancy, or immunosuppressive condition.
- Remicade may not be given with other biologic agents such as Interferon, experimental medications or combinations.
- Remicade may not be given with Enbrel or Kineret.

NOTES:

Available as a Non-Traditional Medicaid Benefit.

INFORMATION:

To be given in clinic setting only. Patients on HMO's (except IHC) will have to make arrangements with their HMO for coverage. Provider will bill with J code J1745 and PA number

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

An updated letter of medical necessity or progress notes showing improvement or maintenance.

05/10/11

<http://health.utah.gov/medicaid/pharmacy>