

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
REMICADE (infliximab)for JUVENILE IDIOPATHIC ARTHRITIS

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 (801) 536-0477**

CRITERIA:

- Age requirement: 4 years old and older
- Diagnosis of Juvenile Idiopathic Arthritis.
- Documentation of failed treatment on at least one DMARD.
- 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.
- Rheumatology consultation within the last 60 days.
- May not be given with other biologic agents such as Interferon, experimental medications or combinations.

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 with medication.

02/15/11

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