OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Remicade® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength: / Dosage Form:
❑ Check if requesting **brand**	Directions for Use:
❑ Check if request is for **continuation of therapy**	

Clinical Information (required)

Continuation of therapy:

Is this a continuation of prior therapy? ❑ **Yes** ❑ **No**

If "yes" to the above question, please submit documentation (e.g., medical records, chart notes, pharmacy claims) or provide the dates, duration, and previous regimen used below: (**REQUIRED)**

_____

_____

Select the diagnosis below:

- ❑ Active ankylosing spondylitis
- ❑ Active psoriatic arthritis
- ❑ Moderate to severe chronic plaque psoriasis
- ❑ Moderately to severely active Crohn's disease
- ❑ Moderately to severely active ulcerative colitis
- ❑ Moderately to severely active rheumatoid arthritis
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber's Specialty:

Is Remicade prescribed by a rheumatologist, dermatologist, or gastroenterologist? ❑ **Yes** ❑ **No**

Clinical Information:

Will the prescriber submit a statement or chart notes documenting the patient has had a failure of two disease modifying anti-rheumatic drugs (DMARDs)? ❑ **Yes** ❑ **No**

Is there presence of contraindications or absolute drug interactions with existing therapy? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following question:

Does the patient show symptom reduction from baseline? ❑ **Yes** ❑ **No**

Remicade® Prior Authorization Request Form (Page 2of 2)

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Quantity Limit Requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

For continuation of existing therapy, also answer the following:

Would sudden discontinuation of the dose trigger withdrawal symptoms? ❑ **Yes** ❑ **No**

Would discontinuation of the dose be unsafe for the patient and their condition may worsen or exacerbate? ❑ **Yes** ❑ **No**

Is the prescribing provider attempting to taper or reduce the dose necessary? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-297-2870.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.