VERMONT

Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Agency of Human Services

~ REMICADE ~

Prior Authorization Request Form

Vermont Medicaid has established coverage limits and criteria for prior authorization of Remicade. In order for beneficiaries to receive Medicaid coverage for Remicade, it will be necessary for the prescriber to telephone or complete and fax this prior authorization request to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Use this form for Remicade prior authorization requests only.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name:____

Phone #:______________________________________

Fax #:____

Address: ______________________________________

Contact Person at Office: ____

Beneficiary:

Name:____

Medicaid ID #:_________________________________

Date of Birth:_______________ Sex:_____________

Will this medication be billed through the: ☐ **pharmacy benefit** or ☐ **medical benefit** (J-code or other code)? **(Please check one)**

Administering Provider if other than Prescriber (name):__________________NPI #:____________

Pharmacy (if known):_________________ Phone:_______________ &/or FAX:_____________

Remicade Infusion: Dose: ____________ Frequency:____________Length of therapy:_____________

Indication:

☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Rheumatoid Arthritis

☐ Ankylosing Spondylitis ☐ Psoriasis (Plaque) ☐ Psoriatic Arthritis

List previous medications tried and failed for this condition:

Name of medication	**Reason for failure**	**Date(s) attempted**

Please explain why self-injectables (if indicated but not trialed) can not be trialed?

____

Prescriber comments:

Prescriber Signature:____________________________________ **Date of this request:**__________________

Last Updated 02/2012