

~ 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 Catamaran. 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/Facility if other than Prescriber (name): \_\_\_\_\_ NPI #: \_\_\_\_\_

Pharmacy (if known): \_\_\_\_\_ Phone: \_\_\_\_\_ &/or FAX: \_\_\_\_\_

Remicade Infusion: Pt weight: \_\_\_\_\_ (kg) Dose: \_\_\_\_\_ (mg/kg) Total Dose: \_\_\_\_\_ (mg)

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: \_\_\_\_\_