



INFLIXIMAB (Remicade®)

PRIOR REVIEW/CERTIFICATION FAXBACK FORM

**INCOMPLETE FORMS MAY DELAY PROCESSING
ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT BCBSNC PROVIDER ID# BELOW**

PRESCRIBER INFORMATION		PATIENT INFORMATION	
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME	
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID	
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH	
PRACTICE ADDRESS	CITY	STATE	ZIP

1. Please **check** the appropriate diagnosis and **answer** the corresponding questions: **Dx code** _____

Fistulizing or moderate to severe Crohn's disease

Moderate to severe psoriatic arthritis (PsA)

Rapidly progressive or moderate to severe rheumatoid arthritis

Ankylosing spondylitis (*please check a. and b.*)

a. Has the patient experienced inadequate symptom relief from at least one conventional drug therapy such as NSAIDS, COX-II inhibitors or methotrexate? Yes No

b. If **NO**, is the patient unable to receive NSAIDS, COX-II inhibitors or methotrexate? Yes No

Severe plaque psoriasis (*affecting more than 10% of patient's body surface area*)

Moderate to severe ulcerative colitis

Mild ulcerative colitis (*please check a. and b.*)

a. Has the patient experienced inadequate symptom relief from conventional drug therapy such as aminosolicylates, corticosteroids or immunosuppressants? Yes No

b. If **NO**, is the patient unable to receive aminosolicylates, corticosteroids or immunosuppressants? Yes No

2. Will the patient be receiving more than one biologic rheumatoid arthritis agent (ex. Enbrel, Humira, Kineret, Orencia or Rituxan) at the same time? Yes No

3. Please indicate whether or not the patient has either of the following conditions:

a. Congestive heart failure (Class III or IV) Yes No

b. Untreated active or latent tuberculosis Yes No

***If you are prescribing **greater than 10mg/kg** dosing of Remicade, please complete and sign **page 2**

Please certify the following by signing and dating below:

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required): _____ Date: _____

**For BCBSNC members, fax form to 1-800-795-9403
For NC State Health Plan members (Member ID YPY), fax form to 1-866-225-5258**

**COMPLETE PAGE 2 ONLY TO REQUEST QUANTITY LIMIT
EXCEPTION FOR REMICADE**

PRESCRIBER INFORMATION		PATIENT INFORMATION
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH
PRACTICE ADDRESS	CITY	STATE ZIP

If you are requesting a quantity above the amount listed, check the appropriate box and provide the medical necessity of the increased dosage requested.

Please note: This medication requires a **prior authorization** before a quantity limit override can be considered. Before submitting a request for a quantity level override, please ensure that a prior approval authorization has been submitted and/or approved (page 1). Otherwise, this request will deny.

Dx Code: _____

Requested drug dose:

greater than 10mg/kg every 4 weeks of Remicade

Provide dosage requested and a description of medical necessity / rationale for this request:

Please certify the following by signing and dating below:

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required): _____ Date: _____

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