



CIGNA

Pharmacy Services

Phone: (800)244-6224

Fax: (800)390-9745

CIGNA HealthCare Prior Authorization Form - Remicade (infliximab) -

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

PROVIDER INFORMATION			PATIENT INFORMATION		
* Provider Name:			**Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed**		
Specialty:	* DEA or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* CIGNA ID:		
Office Fax:			* Date Of Birth:		
* Is your fax machine kept in a secure location? Yes <input type="checkbox"/> No <input type="checkbox"/>			* Patient Street Address:		
* May we fax our response to your office? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		
Medication requested:					
<input type="checkbox"/> Remicade (infliximab) 100mg vial <input type="checkbox"/> Other (please specify):					
Dose and Quantity:		Duration of therapy:		J-Code:	
Frequency of administration:					
Where will this medication be obtained?					
<input type="checkbox"/> CIGNA Tel-Drug (CIGNA's nationally preferred specialty pharmacy)* <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Other (please specify):			<input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Home Health / Home Infusion vendor		
<i>*If you wish to order this medication from CIGNA Tel-Drug, please call 1-800-351-3606 for an order form.</i>					
Diagnosis related to use (please specify):					
<input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Chronic Plaque Psoriasis <input type="checkbox"/> Fistulizing Crohn's disease		<input type="checkbox"/> Psoriatic Arthritis <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Inflammatory Bowel Disease Arthritis		<input type="checkbox"/> Active Ankylosing Spondylitis <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Other (please specify):	
What is the patient's current weight?					
Has this patient been on Remicade in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If YES, what was the previous dosage?					
Does the patient have history of beneficial clinical response to Remicade (infliximab) therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Psoriatic or Reactive Arthritis:					
Does patient have evidence of failure, intolerance or contraindication to Methotrexate therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Rheumatoid Arthritis:					
Will this medication be used in combination with Methotrexate therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Please indicate if the patient has had evidence of failure, inadequate response, intolerance or contraindication to any of the following disease-modifying anti-rheumatic drugs (DMARDs). Please check all that apply:					
<input type="checkbox"/> Methotrexate <input type="checkbox"/> Penicillamine		<input type="checkbox"/> Azathioprine <input type="checkbox"/> Sulfasalazine		<input type="checkbox"/> Gold <input type="checkbox"/> Hydroxychloroquine <input type="checkbox"/> Other (please specify):	
(Continued on page 2)					

Which of the following methods was used to measure the patient's disease progression **PRIOR** to therapy on Remicade? (Check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Health Assessment Questionnaire Disease Index (HAQ-DI) | <input type="checkbox"/> Visual Analogue scale (VAS) |
| <input type="checkbox"/> Likert scales of global response to pain by the patient/doctor | <input type="checkbox"/> Global Arthritis Score (GAS) |
| <input type="checkbox"/> Clinical Disease Activity Index (CDAI) | <input type="checkbox"/> Simplified Disease Activity Index (SDAI) |
| <input type="checkbox"/> Progression of radiographic damage of involved joints | <input type="checkbox"/> Disease Activity Scale (DAS) score |
| <input type="checkbox"/> Disease Activity Score based on 28-joint evaluation (DAS28) score | <input type="checkbox"/> Disease Activity Scale (DAS) score |
| <input type="checkbox"/> Elevation of ESR (> 28 mm/hr), or C-reactive protein (CRP) (2x the upper limit of normal) | |
| <input type="checkbox"/> Other (please specify) : | |

If this is a request for **CONTINUED THERAPY** (after at least 16 weeks of treatment), has the patient shown beneficial response to treatment with Remicade based on any of the following measurements? (Check all that showed a beneficial response to Remicade therapy):

- | | |
|--|---|
| <input type="checkbox"/> Health Assessment Questionnaire Disease Index (HAQ-DI) | <input type="checkbox"/> Visual Analogue scale (VAS) |
| <input type="checkbox"/> Likert scales of global response to pain by the patient/doctor | <input type="checkbox"/> Global Arthritis Score (GAS) |
| <input type="checkbox"/> Clinical Disease Activity Index (CDAI) | <input type="checkbox"/> Simplified Disease Activity Index (SDAI) |
| <input type="checkbox"/> Disease Activity Scale (DAS) score | <input type="checkbox"/> ESR or C-reactive protein (CRP) |
| <input type="checkbox"/> Disease Activity Score based on 28-joint evaluation (DAS28) score | <input type="checkbox"/> Disease Activity Scale (DAS) score |
| <input type="checkbox"/> At least a 20% improvement according to ACR 20% response criteria | |
| <input type="checkbox"/> Other (please specify) : | |

Chronic Plaque Psoriasis:

- Does the patient have history of beneficial clinical response to Remicade (infliximab) therapy? Yes No
- Is the patient a candidate for systemic therapy? Yes No
- Is the severity great enough that the patient is a candidate for Photo Therapy? Yes No
- Is this a request for a renewal of a previously granted authorization? Yes No
- If YES, please document improvement since beginning therapy:

Crohn's Disease:

Has the patient had failure, contraindication, or intolerance to conventional therapies such as aminosalicylate, corticosteroids, or immunomodulators?

- Yes No If YES, please specify which medications:

Did the patient have a failure or intolerance to adalimumab (Humira) therapy? Yes No

Fistulizing Crohn's Disease:

How long have fistulas persisted?

Inflammatory Bowel Disease Arthritis:

Has the patient had failure, contraindication, or intolerance to sulfasalazine, azathioprine, steroids, or, methotrexate?

- Yes No

Ankylosing Spondylitis:

Has the patient had failure, contraindication, or intolerance to non-steroidal anti-inflammatory drugs (NSAIDs)?

- Yes No

Ulcerative colitis:

Has the patient had failure, contraindication, or intolerance to conventional therapies such as corticosteroids (e.g, prednisone, methylprednisolone), 5-aminosalicylic acid agents (e.g., sulfasalazine, mesalamine, balsalazide), or immunosuppressants (e.g., azathioprine, cyclosporine, 6-mercaptopurine)?

- Yes No If YES, please specify which medications:

Additional pertinent information:

Please fax completed form to (800)390-9745.

Our standard response time for prescription drug coverage requests is 2-4 business days. If your request is urgent, it is important that you call Pharmacy Services to expedite the request. View our formulary on line at <http://www.cigna.com>.

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