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 ☐ No ☐ * May we fax our response to your office? Yes ☐ No ☐			* Patient Street Address:		
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		

Medication requested:

☐ Remicade (infliximab) 100mg vial ☐ Other (*please specify*):

Dose and Quantity: Duration of therapy: J-Code:

Frequency of administration:

Where will this medication be obtained?

☐ CIGNA Tel-Drug *(CIGNA's nationally preferred specialty pharmacy)***
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor

**If you wish to order this medication from CIGNA Tel-Drug, please call 1-800-351-3606 for an order form.*

Diagnosis related to use (please specify):

☐ Rheumatoid Arthritis ☐ Psoriatic Arthritis ☐ Active Ankylosing Spondylitis
☐ Chronic Plaque Psoriasis ☐ Ulcerative Colitis ☐ Crohn's disease
☐ Fistulizing Crohn's disease ☐ Inflammatory Bowel Disease Arthritis ☐ Other (please specify):

What is the patient's current weight?

Has this patient been on Remicade in the past? ☐ Yes ☐ No

If YES, what was the previous dosage?

Does the patient have history of beneficial clinical response to Remicade (infliximab) therapy? ☐ Yes ☐ No

Psoriatic or Reactive Arthritis:

Does patient have evidence of failure, intolerance or contraindication to Methotrexate therapy? ☐ Yes ☐ No

Rheumatoid Arthritis:

Will this medication be used in combination with Methotrexate therapy? ☐ Yes ☐ 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:

☐ Methotrexate ☐ Azathioprine ☐ Gold ☐ Hydroxychloroquine
☐ Penacillamine ☐ Sulfasalazine ☐ 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):

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

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