BlueCross BlueShield Federal Employee Program

Send completed form to:
Blue Shield of California
Fax: 1-855-895-3504

REMICADE
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form. All incomplete and illegible forms will be returned to the patient.

CARDHOLDER COMPLETES

Date: ____/ _____/ _____

Cardholder Name: _____/ _____/ _____
First MI Last

Patient Name: _____/ _____/ _____
First MI Last

Patient Address: _____
Street

_____
City State Zip

Patient Date of Birth: ____/ _____/ _____ Sex: M ____ F ____ **R** | | | | | | | | | |
Cardholder Identification Number

PHYSICIAN COMPLETES

1. What is the patient's **diagnosis?**

☐ **Crohn's Disease** ***(aka regional enteritis)*** – ***Answer questions below:***
   a. Does the patient have moderate to severe Crohn's disease, either active or in remission? ☐Yes ☐No*
      If NO, is the patient's Crohn's disease fistulizing? ☐Yes ☐No
   b. If between the ages of 6-17, will all vaccinations be up to date prior to start of therapy? ☐Yes ☐No

☐ **Ulcerative Colitis** – ***Answer questions below:***
   a. Does the patient have moderate to severe active ulcerative colitis? ☐Yes ☐No
   b. Has there been inadequate response to conventional therapy, unless contraindicated or intolerant? ☐Yes ☐No
   c. If between the ages of 6-17, will all vaccinations be up to date prior to start of therapy? ☐Yes ☐No

☐ **Rheumatoid Arthritis** – ***Answer questions below:***
   a. Does the patient have moderate to severe active rheumatoid arthritis? ☐Yes ☐No
   b. Is the patient using concurrent therapy with methotrexate? ☐Yes ☐No*
      If NO, is the patient contraindicated or intolerant to the use of methotrexate? ☐Yes ☐No

☐ **Ankylosing Spondylitis** – ***Answer question below:***
   a. Is the patient's ankylosing spondylitis active? ☐Yes ☐No

☐ **Psoriatic Arthritis** – ***Answer question below:***
   a. Is the patient's psoriatic arthritis active? ☐Yes ☐No

☐ **Plaque Psoriasis** – ***Answer questions below:***
   a. Is the patient's plaque psoriasis chronic severe (i.e., extensive and/or disabling)? ☐Yes ☐No
   b. Has there been inadequate response to conventional therapy, unless contraindicated or intolerant? ☐Yes ☐No

☐ **Other** (***please specify***)**:** _____

2. Will Remicade be used in combination with another biologic agent? ☐Yes ☐No

3. Is this the **INITIATION** or **CONTINUATION** of Remicade therapy?

☐This is the **INITIATION** of Remicade therapy – ***Answer questions below:***
   a. Has the patient had a TB test prior to initiating therapy that confirms no active tuberculosis? ☐Yes ☐No*
      If NO, does the patient have a latent tuberculosis infection? ☐Yes* ☐No
      If YES, has the patient started treatment for the infection prior to the use of Remicade? ☐Yes ☐No
   b. Does the patient have any active infections? ☐Yes ☐No
   c. Is the patient at risk for Hepatitis B infection (HBV)? ☐Yes* ☐No
      If YES, has HBV been ruled out for this patient or has therapy been started for treatment of the HBV infection? ☐Yes ☐No

☐This is the **CONTINUATION** of Remicade therapy – ***Answer questions below:***
   a. Has the patient's condition improved or stabilized? ☐Yes ☐No
   b. Does the patient have any active infections including tuberculosis (TB) and Hepatitis B (HBV)? ☐Yes ☐No

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. Prescriber Certification: I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer.

Physician Name (Print Clearly)	( ) Phone	( ) Fax

Street Address	City	State	Zip

Prescriber's NPI	Physician Signature	/ / Date

Remicade - CSU
Revised 8/25/2015