

Date of Request _____

Remicade **Remicade (Infliximab) is a tumor necrosis factor antagonist used for moderate to severe rheumatoid arthritis, ulcerative colitis, ankylosing spondylitis, or psoriatic arthritis in patients \geq 18 years of age.**

Patient must have tested negative for latent tuberculosis.
 Patient must have failed (or intolerant to) adequate trial with methotrexate.
 Patient must not use in conjunction with Kineret or Orencia. [3 months]
 For reevaluation- symptomatic improvement as indicated by two of the following: reduction in ESR or C-reactive protein level, improvement in functional status, improvement in radiographic examination of involved joints, or reduction in duration of morning stiffness or fatigue. [12 months]

OR for the treatment of moderate to severe or fistulizing Crohn's Disease in patients \geq 6 years of age.
 Must be prescribed by a gastroenterologist.
 Patient must have tested negative for latent tuberculosis.
 Induction therapy-Patient failed (or intolerant to) Mesalamine or Sulfasalazine, Corticosteroids, and Immunomodulators. [10 weeks]
 Maintenance therapy- Patient showed improvement after induction therapy. [10 months]

Member Information

Name _____
 Enrollment / Cardholder ID _____
 Group / Plan _____
 Birth date _____
 Address: _____
 City State Zip _____

Relationship (Circle)

Subscriber Spouse Dependent

Gender (Circle)

Male Female

AGE: _____ Weight (kg): _____

Practitioner Information

Name _____
 Agent / Contact Name _____
 Specialty _____
 Office / Clinic Name _____
 Address _____
 City State Zip _____

Phone () - _____
 Fax () - _____
 ID Number _____
 Email @ _____

Previous use? Y N
 Negative latent TB test? Y N
 Using with Kineret or Orencia? Y N

Requested Drug / Pharmaceutical

Remicade (Infliximab)

Strength / Dose

Therapy Start Date

Duration of Therapy (Expected)

Type of Request (Circle)

One-Time On-Going

Condition / Diagnosis Related - Reason for Request

Clinical Drug / Lab History Pertinent to Request

Labs: Baseline / Ongoing

Formulary Alternative(s) Attempted YES NO (Circle)
 Please List:

Contact Pharmacy? Y N

Pharmacy Phone Number

Practitioner Signature