CVS CAREMARK

Fax Referral To: 800-323-2445
Phone: 866-278-6634

Remicade® (infliximab)
Enrollment Form
For Blue Cross Blue Shield of Rhode Island Members

Date: _____ **Needs by Date (Please Specify):** _____

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** _____

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
Last Four of SS #: _____ Primary Language: _____
Insurance ID: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____
Contact Phone: _____

INSURANCE INFORMATION (*Please copy and attach the front and back of insurance and prescription drug card)*

Prescription Card: Name of Insurer: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____
Primary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: **Blue Cross Blue Shield of RI** Phone: _____
Secondary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 code):

☐ 714.0 Rheumatoid Arthritis ☐ 696.0 Psoriatic Arthritis • Date of Diagnosis: _____
☐ 555.0 Regional Enteritis or Crohn's Disease of Small Intestine ☐ 555.9 Regional Enteritis or Crohn's Disease NOS
☐ 555.1 Regional Enteritis or Crohn's Disease of Large Intestine ☐ Other: _____

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

- Patient has hypersensitivity to any murine proteins or other components of the product ☐ Yes ☐ No
- Patient has moderate to severe (NYHA Class III/IV) Congestive Heart Failure (CHF) ☐ Yes ☐ No
- Patient has developed new symptoms or worsening symptoms of pre-existing CHF ☐ Yes ☐ No
- Patient has Tuberculosis or a history of recurrent infection, current chronic infection, or clinically important infection ☐ Yes ☐ No
- Patient has had a tuberculin skin test to rule out latent tuberculosis ☐ Yes ☐ No
- Remicade will be used in combination with other TNF blockers, anakinra (Kineret), or abatacept (Orencia) ☐ Yes ☐ No

Rheumatoid Arthritis:

- Patient has a diagnosis of moderately to severely active Rheumatoid Arthritis ☐ Yes ☐ No
- Patient is 18 years of age or older ☐ Yes ☐ No
- Patient is currently receiving methotrexate (MTX) ☐ Yes ☐ No
  - If no, is the patient intolerant or contraindicated to MTX ☐ Yes ☐ No
  - Is the patient receiving another immunosuppressive agent that prevents development of human anti-chimeric antibodies (HACA) (i.e. azathioprine, cyclosporine, or sulfasalazine) ☐ Yes ☐ No
- Patient has had an inadequate response to one or more DMARDs (disease-modifying antirheumatic drugs such as azathioprine, gold, hydroxychloroquine, leflunomide, methotrexate, and sulfasalazine) ☐ Yes ☐ No

Crohn's Disease:

- Patient is 6 years of age or older ☐ Yes ☐ No
- Patient has moderately to severely active Crohn's disease ☐ Yes ☐ No
- Patient has one or more of the following symptoms: Check boxes that apply: ☐ Yes ☐ No
  - ☐ Abdominal Pain
  - ☐ Bleeding
  - ☐ Diarrhea
  - ☐ Extraintestinal manifestations (arthritis, uveitis, iritis, pyoderma gangrenosum, erythema nodosum, or spondylitis)
  - ☐ Internal fistulae
  - ☐ Intestinal obstruction
  - ☐ Perianal disease
  - ☐ Megacolon
  - ☐ Weight loss
- Patient had an inadequate response to conventional therapy [oral mesalamine, oral corticosteroids, and 6-mercaptopurine or azathioprine (6-MP/AZA)] ☐ Yes ☐ No
- Patient has fistulizing Crohn's disease with draining enterocutaneous or rectovaginal fistulas, of at least 3 months duration ☐ Yes ☐ No
- Patient has fistulizing or moderately to severely active Crohn's disease and have responded to previous therapy with Remicade ☐ Yes ☐ No

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Ulcerative Colitis:

- Patient is 6 years of age or older ☐ Yes ☐ No
- Patient has diagnosis of moderately to severely active Ulcerative Colitis ☐ Yes ☐ No
- Patient has had an inadequate response to conventional therapy ☐ Yes ☐ No

Active ankylosing spondylitis (adult)**:**

- Patient is 18 years of age or older ☐ Yes ☐ No
- Patient has diagnosis of active ankylosing spondylitis ☐ Yes ☐ No
- Patient has failed, had an inadequate response or is contraindicated to conventional therapy (e.g., nonsteroidal anti-inflammatory drugs, sulfasalazine, or methotrexate) ☐ Yes ☐ No

Active psoriatic arthritis (adult)**:**

- Patient is 18 years of age or older ☐ Yes ☐ No
- Patient is a pregnant woman or nursing mother ☐ Yes ☐ No
- Patient has active arthritis with at least 5 swollen joints and 5 tender joints ☐ Yes ☐ No
- Is the patient currently receiving systemic therapy for psoriatic arthritis (**except** methotrexate) or immunosuppressive therapy? ☐ Yes ☐ No
- Patient has failed or is contraindicated to conventional treatment including DMARDs ☐ Yes ☐ No

Patient has arthritis in any of the following distributions:

- Distal interphalangeal joint involvement ☐ Yes ☐ No
- Polyarticular arthritis, without rheumatoid nodules ☐ Yes ☐ No
- Arthritis mutilans ☐ Yes ☐ No
- Asymmetric arthritis ☐ Yes ☐ No
- Ankylosing spondylitis-like arthritis ☐ Yes ☐ No

Chronic Plaque Psoriasis:

- Patient has failed or is intolerant or contraindicated to, other systemic therapies (e.g., methotrexate, acitretin, or cyclosporine) ☐ Yes ☐ No
- Patient has greater than 10% of body surface area with plaque psoriasis ☐ Yes ☐ No
- Patient has less than or equal to 10% body surface area with plaque psoriasis involving sensitive areas or areas that would significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia) ☐ Yes ☐ No

Juvenile Idiopathic Arthritis:

- Patient has moderately to highly active arthritis ☐ Yes ☐ No
- Patient had an inadequate response to or is intolerant/contraindicated to methotrexate or leflunomide ☐ Yes ☐ No
- Patient had an inadequate response to or is intolerant/contraindicated to etanercept (Enbrel) and adalimumab (Humira) ☐ Yes ☐ No

Other Uses:

- Patient has a diagnosis of Reactive Arthritis (Reiter's Syndrome) ☐ Yes ☐ No
- Patient has a diagnosis of Arthritis associated with Inflammatory Bowel Disease ☐ Yes ☐ No
- Patient is 18 years of age or older ☐ Yes ☐ No

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Remicade® (infliximab)	100mg Vial Weight _____ kg/lbs _____ mg/kg	☐ Induction Dose: IV in 250ml of 0.9% NaCl at weeks 0, 2, and 6 weeks. (*ICD-9: 714.0, 696.0, & 720.0*) ☐ Maint. Dose: IV in 250ml of 0.9% NaCl every 8 weeks. (*ICD-9: 714.0 & 696.0*) ☐ Maint. Dose: IV in 250ml of 0.9% NaCl every 6 weeks. (*ICD-9: 720.0*) ☐ Other: _____	_____ # of 100mg vials	

X _____
PRODUCT SUBSTITUTION PERMITTED (Date)

X _____
DISPENSE AS WRITTEN (Date)