Date _____

Client _____

PRIOR AUTH QUESTIONNAIRE - REMICADE®

M.D. Last Name: _____ ***M.D. First Name:*** _____

Physician Phone: _____ ***Physician Fax:*** _____

Patient _____ ***ID#*** _____ ***DOB*** _____

TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.

PLEASE NOTE: ***FOR ALL REQUESTS, PLEASE ATTACH THE MOST RECENT COPY OF THE PATIENT'S PROGRESS NOTES***

1. Please indicate patient's diagnosis:
   - ☐ Rheumatoid Arthritis (Continue to #2)
   - ☐ Crohn's Disease (SKIP to #3)
   - ☐ Fistulizing Crohn's Disease (SKIP to #3)
   - ☐ Psoriatic Arthritis (SKIP to #5)
   - ☐ Ankylosing spondylitis (SKIP to #5)
   - ☐ Plaque Psoriasis (SKIP to #4)
   - ☐ Ulcerative Colitis (SKIP to #3)
   - ☐ Other*_____

   ***Note: If "Other" diagnosis is used, please attach a study with efficacy data supporting this request**

2. Is the patient taking or has the patient failed a trial of methotrexate? (if YES, Skip to #5) Yes No

3. Please check if the patient has tried any of the following: (Skip to #5)
   - ☐ Mesalamine or derivative
   - ☐ Sulfasalazine
   - ☐ Azathioprine
   - ☐ Injectable or oral corticosteroids
   - ☐ Injectable cyclosporine
   - ☐ Mercaptopurine

4. Please check if the patient has tried any of the following: (Continue to #5)
   - ☐ Retinoids
   - ☐ DMARD's (methotrexate)
   - ☐ Immunosuppressants
   - ☐ Phototherapy

5. List other anti-TNF agents that the member has tried/failed and dates: _____

6. Dose to be used (mg/Kg) _____ Frequency (how often given in weeks): _____

7. Patient Weight: (Kg) _____ Duration of Therapy: _____

8. Does the patient have moderate-to-severe heart failure? Yes No
9. Does the patient have a clinically important infection? Yes No
10. Has the patient had a TB test? Yes No

Physician Signature or name of person providing answers _____

Physician Comments _____

_____

Send or Fax completed form to:
877-329-7279

RESTAT
P.O. BOX 758
WEST BEND. WI 53095

QUESTIONS PLEASE CALL:
877-526-9906