Prior Authorization Request Nevada
Medicaid – Molina Healthcare

# Remicade® (infliximab)

Please provide the information below. Please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request. **FAX responses to: (844) 259-1689. Phone: (833) 685-2103**.

| **DATE OF REQUEST:** | | |
|---|---|---|
| **MEMBER INFORMATION** | | |
| Last Name, First Name, Middle Initial: | | Date of Birth: |
| Molina ID: | Gender: ☐ Male ☐ Female | Phone: |
| **PRESCRIBING PROVIDER INFORMATION** | | |
| Name: | NPI: | Specialty: |
| Phone: | Fax (required): | |
| Person to contact regarding this request: | | |
| **DIAGNOSIS AND REQUESTED DRUG** | | |
| Name: **Remicade** | Strength: | |
| Dosage: | Duration: | |

*Please document the recipient's diagnosis*:

☐ Ankylosing Spondylitis
- ☐ The recipient has had an inadequate response to NSAIDS or contraindication to treatment with an NSAID.

☐ Psoriatic Arthritis
- ☐ The recipient has had an inadequate response to NSAIDS or contraindication to treatment with an NSAID.

☐ Plaque Psoriasis
- ☐ The recipient has failed to adequately respond to a topical agent.

☐ Ulcerative Colitis
- ☐ The recipient has a diagnosis of moderate to severe ulcerative colitis.
- ☐ Recipient has failed to adequately respond to 1 or more of the following standard therapies: corticosteroids, 5-aminosalicylic acid agents, immunosuppresants and/or Thiopurines.

☐ Crohn's Disease

☐ Rheumatoid Arthritis

☐ Other:_____

## CLINICAL INFORMATION

*Check the applicable boxes to indicate each item as true for the recipient:*

☐ The recipient has had a rheumatology consult. Date:_____Duration of disease:_____**(if applicable)**.

☐ The recipient has had a dermatology consult. Date:_____Duration of disease:_____**(if applicable)**.

☐ The recipient has fistulizing Crohn's disease **(Crohn's disease only)**.

☐ The recipient has mild disease activity.

☐ The recipient has moderate disease activity.

☐ The recipient has high/severe disease activity.

☐ The recipient does not have moderate to severe heart failure (NYHA class III or IV).

☐ The recipient does not have a history of treated lymphoproliferative disease in the previous 5 years.

☐ The recipient does not have acute or chronic liver disease classified as Child-Pugh class B or C.

☐ The recipient does not have multiple sclerosis or another demyelinating disorder.

☐ The recipient does not have an active infection or history of recurring infections.

☐ The recipient has had a negative tuberculin test prior to initiating requested treatment.

☐ The recipient has had a positive tuberculin test prior to initiating requested treatment.

☐ Treatment with isoniazid was started ≥1 month prior to initiating requested treatment **(only if test was positive)**.

☐ The recipient has an allergy, history of unacceptable/toxic side effects, drug-drug interaction or therapeutic failure with Cimzia®, Enbrel® and Humira® (if indicated for diagnosis). *Please document*:_____

☐ Remicade® is being requested for a unique indication that is supported by peer-reviewed literature or a unique FDA-approved indication (document diagnosis above).

*List the medications that were tried and failed for the given diagnosis:*

| Drug Name | Reason for Failure | Date(s) |
|---|---|---|
| | | |
| | | |

*Additional clinical information (if applicable):*

**PROVIDER CERTIFICATION** – *Prescriber's signature and date required.*

**I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Nevada Medicaid.**

**Prescriber's Signature:** _____ **Date:** _____

* Authorization will not be given for the use of more than one biologic at a time (combination therapy).