



REMICADE® FOR IBD SYNDROME

NH Medicaid Prior Authorization Request Form

Fax to First Health if medication is to be dispensed from a pharmacy

First Health: Fax: 1-888-603-7696 Phone: 1-866-675-7755

Fax to Schaller Anderson if medication is dispensed and administered by a physician

Schaller Anderson: Fax: 1-866-499-9334 Phone: 1-866-499-9335



SCHALLER ANDERSON

***NOTE: If this request is for Remicade® to treat ankylosing spondylitis, plaque psoriasis, psoriatic arthritis, or rheumatoid arthritis (RA) please fill out the DMARD fax form.**

Date of Medication Request: ____ / ____ / ____

Section I: Patient Information and Medication Requested

Name (Last, First): _____

NH Medicaid Number: _____

Date of Birth: ____ / ____ / ____

Gender: Male Female

Drug Name: _____ Strength: _____

Dosing Schedule: _____ Length of Therapy: From ____/____/____ to ____/____/____

Numbers of injections required/requested: _____

Section II: Clinical History

1. Patient's diagnosis for use of this medication (please be complete, including endoscopy results):

2. Indicate if the prescriber is a rheumatologist, gastroenterologist, or a dermatologist: _____

3. Previous failure, contraindication, or adverse reaction to:

Oral or IV Corticosteroid: Yes No Azothioprine or Mercaptopurine (3 month trial): Yes No

IV Cyclosporine: Yes No Parenteral MTX (3 month trial): Yes No

Oral or rectal aminosalicylates (2 month trial): Yes No

4. If drug is being prescribed for treatment of fistulizing Crohn's Disease, was fistula confirmed via endoscopy? Yes No

5. Does patient have heart failure? Yes No

If yes, please provide NYHA classification: _____

6. Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page. _____

****Please be advised that written supportive documentation of medication trials and diagnosis is required.**

Section III: Prescriber Information

Name: _____ Medicaid Provider ID Number: _____

Phone Number: (____) _____ - _____ Fax Number: (____) _____ - _____

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Signature of Prescribing Provider