



PRIOR AUTHORIZATION REQUEST FORM

Inflammatory Bowel Disease
(Cimzia®, Humira®, Remicade®, Tysabri®)

DATE OF REQUEST: _____

MEMBER INFORMATION

NAME _____

ID # _____

BIRTHDATE _____

PLEASE NOTE: By signing this form, you are attesting to the accuracy of the information provided, and that medical record documentation is available if requested.

PROVIDER INFORMATION

NAME _____

NPI # _____

ADDRESS _____

PHONE # _____ FAX # _____

CONTACT NAME _____

PROVIDER SIGNATURE _____

Cimzia **IV** Cimzia **SQ** Humira Remicade Tysabri

Dose/frequency: _____

If *not* obtained at a pharmacy for self administration:

- Obtain at MVP's specialty pharmacy (CuraScript) for office administration (*may be required*)
- Office/Hospital/ Infusion Center: Place of Service _____
- Other _____

Diagnosis _____

ICD-9 code _____

Please check one **Initial Request**

Extension Request

MOST RECENT ENDOSCOPY REPORT MUST BE SENT WITH THIS REQUEST

THE FOLLOWING INFORMATION MUST BE COMPLETED IN FULL

IF FISTULIZING CROHN'S DISEASE, HOW LONG HAS MEMBER BEEN SYMPTOMATIC: _____

LOCATION OF FISTULA: _____ BOWEL RELATED ABCESS: YES NO

NUMBER OF LIQUID STOOLS/DAY: _____ WEIGHT LOSS > THAN 10%: YES NO

ANEMIA: YES NO ABDOMINAL MASS: YES NO FEVER: YES NO

OVERALL ABDOMINAL PAIN: NONE MILD MODERATE SEVERE

GENERAL WELL-BEING: WELL UNDERPAR POOR VERY POOR TERRIBLE

EXTRA-INTESTINAL SYMPTOMS (PROVIDE DOCUMENTATION): YES NO

ESR: _____ HCT: _____ TB SKIN TEST: _____ HISTORY OF CHF YES (indicate class) _____ NO

LIST CURRENT AND PAST THERAPY AND PATIENT RESPONSE BELOW:

PLEASE NOTE: ALL CHART NOTES/LAB REPORTS IN REFERENCE TO THIS REQUEST MUST BE RECEIVED BEFORE A REVIEW CAN BEGIN. *REQUESTS SUBMITTED WITHOUT THIS DOCUMENTATION MAY BE DENIED.*

FAX THIS REQUEST TO:

Commercial **1-800-376-6373**

(HMO, EPO/PPO, Option, Option Child, Option Family, Healthy NY, Personal Plan, CompCare, ASO)

Medicare Part D **1-800-401-0915**

(Preferred Gold, GoldAnywhere, GoldValue, USA Care, MVP RxCare)