**Kansas Medical Assistance Program**
P O Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593
Beneficiary 1-800-766-9012

# Infliximab (Remicade®)
# Prior Authorization Request Form

## Beneficiary Information

Beneficiary Name: _____

Beneficiary Medicaid ID #: _____ Date of Birth: ___/___/_____

## Billing Provider Information (Physician OR Facility)

Billing Provider's Name: _____

Provider Medicaid ID#: _____ Provider NPI#: _____

Phone Number: (_____) _____ Fax Number: (_____) _____

Procedure Code Requesting: _____ Total # of Units Requesting (per 6 months): _____

## Prescriber Information

Prescriber's Name: _____

Prescriber's Medicaid ID#: _____ Prescriber's NPI#: _____

Phone Number: (_____) _____ Fax Number: (_____) _____

## Requested Information

1. Please indicate the diagnosis and severity for which Remicade is being prescribed (no diagnosis codes):

   _____

2. What specialty is the prescriber? Rheumatologist _____ Dermatologist _____

   Gastroenterologist _____ Other (please specify) _____

3. TB skin test results:

   Date of test: ___/___/_____ Positive _____ Negative _____

4. **For Rheumatoid Arthritis** – Is the patient currently taking methotrexate?

   Yes _____ No _____

5. **For Crohn's Disease or Ulcerative Colitis** – Document inadequate response to conventional therapies:

   _____

6. **For Plaque Psoriasis** – Is the patient a candidate for systemic therapy or phototherapy?

   Yes _____ No _____

Prescriber's Signature: _____ Date: ___/___/_____

**Completed form should be faxed to the Prior Authorization Unit at 1-800-913-2229.**
**This form will be returned unprocessed if it is not completed in its entirety.**