MEDICARE ADVANTAGE DRUGS/BIOLOGICS PART B PRECERTIFICATION FORM

PART B STEP THERAPY - REMICADE

This precertification form applies to Arizona health plans only.
Please fax to: **1-877-730-3858** | Phone: **1-888-454-0013**

Note: In an effort to process your request in a timely manner, please submit all pertinent clinical information.

☐ **Expedited – defined as danger to a patient's health if not provided within 24 hours**		
Patient name:		Patient date of birth:
Name of requesting provider:		ID number:
Contact person:		Date of service:
Address:		
NPI number:	Phone number:	Fax number:

If referring to a (servicing) provider, the below stated information must be submitted:	
Name of servicing provider:	Phone number:
Contact person:	Fax number:
Address:	NPI number:
☐ Please check if servicing provider is non-contracted If servicing provider is non-contracted/out-of-network provider/facility, please explain why:	
Who will supply the medication? ☐ Provider office ☐ Outpatient hospital/clinic ☐ Pharmacy not located within the servicing facility	Please select place of service by checking only one of the boxes: ☐ Provider office ☐ Outpatient hospital/clinic ☐ Other. Please specify:
Diagnosis codes:	Diagnosis:

Please attach all required documentation: recent clinical notes, copy of the prescription or physician order, relevant diagnostic labs.

HCPCS codes	**Drug name** (if applicable)	**Dose** (if applicable)	**Frequency**	**Duration**

Q1: Is this a new start or a continuation of therapy within the past 365 days?

Q2: Has the patient had an intolerance or an inadequate response to a Step 1 alternative Renflexis®, Inflectra®, or Avsola™ ?

Q3: If patient is unable to try a Step 1 alternative Renflexis®, Inflectra®, or Avsola™, please provide the reason(s) why an exception should be made to the step therapy requirement: