

**PRIOR AUTHORIZATION PROGRAM REIMBURSEMENT REQUEST FORM** Please fax form to:  
**For biologic response modifier: Remicade® (infliximab)** 1-866-840-1509

Please note that the patient AND physician must complete this form. All fields are mandatory and must be completed. Incomplete forms may result in your application being declined. Please retain a copy of this form for your records.

**Instructions:**

1. PLEASE PRINT CLEARLY AND COMPLETE ALL SECTIONS.
2. The patient/plan member must complete section A.
3. Your physician must complete section B. The cost, if any, of completing this form is at the expense of the patient/plan member.
4. Please return the form to your insurance company via Pharmacy Services at Emergis Inc. (a service provider of your insurance company) by fax to 1-866-840-1509, OR mail to Emergis Inc., 4141 Dixie Rd. P.O. Box 41154, Mississauga, Ont. L4W 5C9.
5. If you have any questions on the application of this program or the decision on reimbursement, or to inquire on the status of your Reimbursement Request Form, please contact your insurer.

**A. Information to be Completed by Patient**

Employee or Insured's Name	Drug Card Number		
Patient's Name	Patient's Date of Birth (D/M/Y)	Relationship to Employee/Insured (please circle)	
	/ /	Employee	Spouse    Dependant

**Please allow two business days for a response once all information is received and complete. Notification of the results of this request will occur Monday to Friday between 9 am and 4 pm Eastern Time.**

Please provide contact information and indicate ONE method of preferred contact for notification of the results:

- e-mail me at: \_\_\_\_\_
- call me (and leave a message if I'm not there) at: (\_\_\_\_) \_\_\_\_\_
- fax me at: (\_\_\_\_) \_\_\_\_\_
- contact my pharmacy at pharmacy name: \_\_\_\_\_ phone no.: (\_\_\_\_) \_\_\_\_\_

I certify that the information provided by me is true, correct and complete to the best of my knowledge. I authorize my insurance company, Emergis Inc. (a service provider of my insurance company), their authorized representatives, agents and service providers to use and exchange this information needed for underwriting, administration and paying claims with any person or organization who has relevant information pertaining to this claim including health professionals, institutions and investigative agencies in the event of an audit. I authorize my insurance company and/or Emergis Inc. (a service provider of my insurance company) to contact any licensed physician, institution, pharmacy or person who has any records or knowledge of me or my health with respect to this submitted claim.

SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN \_\_\_\_\_ Date (D/M/Y): \_\_\_\_\_

**B. Information to be Completed by Prescribing Physician**

Drug Name: \_\_\_\_\_ Strength: \_\_\_\_\_ Dose: \_\_\_\_\_

Remicade® will be eligible for reimbursement only if the patient satisfies one of the criteria listed below and if the patient does not qualify for coverage under any other drug plan or government mandated program. If the patient is covered under another drug plan or government mandated program, the prior authorization program, as part of your drug benefits, may cover the portion not paid for by the primary plan. However, if "none of the above criteria" is indicated, the patient will not be eligible for reimbursement.

Please indicate if the patient satisfies one of the following criteria:

- Use in combination with methotrexate for the reduction in signs and symptoms, inhibition of the progression of structural damage, and improvement in physical function in adult patients with moderately to severely active rheumatoid arthritis.
- For the reduction of signs and symptoms and improvement in physical function in patients with active ankylosing spondylitis who have responded inadequately, or are intolerant to, conventional therapies.
- For the reduction of signs and symptoms and induction and maintenance of clinical remission in adult and pediatric patients with moderately to severely active Crohn's disease who have had an inadequate response to conventional therapy. The safety and efficacy of Remicade® is not established in patients less than 9 years of age.
- For the treatment of fistulising Crohn's disease, in adult patients who have not responded despite a full and adequate course of therapy with conventional treatment.
- For reducing signs and symptoms, inducing and maintaining clinical remission and mucosal healing, and reducing or eliminating corticosteroid use in patients with moderately to severely active ulcerative colitis who have had an inadequate response to conventional therapy.
- For the reduction of signs and symptoms, induction of major clinical response, and inhibition of the progression of structural damage of active arthritis, and improvement in physical function in patients with psoriatic arthritis.
- For the treatment of adult patients with chronic moderate to severe plaque psoriasis who are candidates for systemic therapy. For patients with chronic moderate plaque psoriasis, Remicade® should be used after phototherapy has been shown to be ineffective or inappropriate.

OR

- None of the above criteria applies.

Physician's Name	License Number	Telephone Number	Fax Number
Address	City	Province	Postal Code
Physician's Signature			Date (DD/MM/YYYY)