

# AccessOne® to One Physician Plan of Treatment for REMICADE® (infliximab)

Please complete this form and provide to AccessOne® by calling (888) ACCESS-1 (222-3771) Monday through Friday between the hours of 8:00 AM and 8:00 PM (ET) or by faxing it to (866) 489-5955.

## Patient Information

Name \_\_\_\_\_ Sex  M  F DOB(mm/dd/yyyy) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ ZIP Code \_\_\_\_\_ Email \_\_\_\_\_  
Work Phone \_\_\_\_\_ Home/Cell Phone \_\_\_\_\_ SS# \_\_\_\_\_  
Patient may be contacted at:  Work  Home/Cell Best time \_\_\_\_\_

## Patient Insurance Information (Please include alpha prefix and suffix when applicable)

If available, attach copy of both sides of patient's insurance card(s).  Check if no insurance.  
Primary Insurance \_\_\_\_\_ Secondary Insurance \_\_\_\_\_  
Policy # \_\_\_\_\_ Policy # \_\_\_\_\_  
Group # \_\_\_\_\_ Group # \_\_\_\_\_  
Policy Holder's Name \_\_\_\_\_ Policy Holder's Name \_\_\_\_\_  
Insurance Co. Phone \_\_\_\_\_ Insurance Co. Phone \_\_\_\_\_  
Prescription Drug Insurer \_\_\_\_\_ Card/BIN# \_\_\_\_\_ Phone \_\_\_\_\_

## Prescriber Information

Prescribing Physician \_\_\_\_\_ Practice Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ ZIP Code \_\_\_\_\_ Email \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_ Office Contact \_\_\_\_\_  
Provider # (as it pertains to commercial insurance below) \_\_\_\_\_ Medicaid/Medicare provider # \_\_\_\_\_  
Tax ID # \_\_\_\_\_ UPIN/NPI # \_\_\_\_\_

## Clinical Information—Primary Diagnosis (Required)

If using more than one diagnosis, please circle the primary diagnosis.

**Psoriasis** **Psoriatic Arthritis**  
 696.1 Psoriasis  696.0 Psoriatic arthropathy

Comment/Other \_\_\_\_\_ Date of diagnosis or years with disease \_\_\_\_\_

## Referral to Specific Provider

Referral Source Unknown  Home Infusion/Infusion Provider Company \_\_\_\_\_  
 Referral to \_\_\_\_\_ Telephone \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

## Therapy with REMICADE®

Previous TB Test (Date) \_\_\_\_\_ Dosage/Frequency \_\_\_\_\_  
Patient Weight \_\_\_\_\_ lb. \_\_\_\_\_ kg. Number of Vials to Be Used \_\_\_\_\_  
Anticipated Number of Infusions \_\_\_\_\_ Number of Prior Infusions with REMICADE®:  0  1-3  4+  
 Please supply treatment notes to prescribing practice contact at fax number listed above  It is not necessary to send treatment notes

## PRESCRIBER SIGNATURE REQUIRED TO VALIDATE PRESCRIPTION

I certify that therapy with REMICADE® is medically necessary for this patient. I will be supervising the patient's treatment accordingly.

Prescriber Signature \_\_\_\_\_ Date \_\_\_\_\_

Supervising Physician's Signature (if applicable) \_\_\_\_\_

To comply with the HIPAA Privacy Rule, AccessOne® must have a signed patient authorization and/or business associate contract on file.

Patient insurance benefit investigation is provided as a service by TheraCom, LLC, and The Lash Group, Inc., under contract for Centocor Ortho Biotech Inc. In this regard, TheraCom, LLC, and The Lash Group, Inc., assist healthcare professionals in the determination of whether treatment could be covered by the applicable third-party payer based on coverage guidelines provided by the payer and patient information provided by the healthcare provider under appropriate authorization following the providers' exclusive determination of medical necessity.

Importantly, insurance verification is the ultimate responsibility of the provider. Third-party reimbursement is affected by many factors. Therefore, TheraCom, LLC, The Lash Group, Inc., and Centocor Ortho Biotech Inc. make no representation or guarantee that full or partial insurance reimbursement or any other payment will be available. This information is provided as an information service only. While TheraCom, LLC, and The Lash Group, Inc., try to provide correct information, they and Centocor Ortho Biotech Inc. make no representations or warranties, expressed or implied, as to the accuracy of the information. In no event shall TheraCom, LLC, The Lash Group, Inc., or Centocor Ortho Biotech Inc. or its employees or agents be liable for any damages resulting from or relating to the services. All providers and other users of this information agree that they accept responsibility for the use of this service.

Centocor Ortho Biotech Inc. assumes no responsibility for, and does not guarantee the quality, scope, or availability of reimbursement services. Each provider, not Centocor Ortho Biotech Inc. is responsible for the services they provide. This reimbursement support service has no independent value to providers apart from the product and is included within the cost of the product.

Please see accompanying Indications, Important Safety Information, and full Prescribing Information, also available at [www.centacoraccessone.com](http://www.centacoraccessone.com)



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