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Inflectra (infliximab-dyyb), Remicade (infliximab) Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004
Provider Help Desk 1-800-454-3730

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
Inflectra (infliximab-dyyb), Remicade (infliximab)	_____	_____	Specify: _____

7. Diagnosis: _____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Required for All Requests:

□ Yes □ No Patient has been screened for hepatitis B and C, AND it has been confirmed that this patient does **NOT** have active hepatitis B. Patients with evidence of active Hepatitis B infection (Hepatitis surface antigen positive > 6 months) must have documentation they are receiving or have received effective antiviral treatment

□ Yes □ No Patient has been treated for solid malignancies, non-melanoma skin cancer, or lymphoproliferative malignancy within the last 5 years of starting or resuming treatment with a biological agent [**PLEASE NOTE**: Biological agents include: Abatacept (Orencia); Adalimumab (Humira); Anakinra (Kineret); Certolizumab Pegol (Cimzia); Etanercept (Enbrel); Infliximab (Remicade); Golimumab (Simponi); Tocilizumab (Actemra); Ustekinumab (Stelara); Secukinumab (Cosentyx)]

□ Yes □ No Patient has a diagnosis of congestive heart failure (CHF) that is New York Heart Association (NYHA) class lll or lV and with an ejection fraction of 50% or less

□ Yes □ No Patient has been screened for latent TB infection **[PLEASE NOTE**: patients with latent TB will only be considered after one month of TB treatment and patients with active TB will only be considered upon completion of TB Treatment]

□ Yes □ No Patient had a previous trial and therapeutic failure with **TWO** preferred biological medications [Please Note the **PREFERRED** biologic medications are: Cosentyx, Enbrel, and Humira.]
*__DOCUMENTATION__ must be submitted which includes the following information: that the patient had previous trials and therapy failures with two preferred biologicals. Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.

□ Yes □ No Patient have a medical contraindication to the use of the preferred medications
[Please Note the PREFERRED biologic medications are: Cosentyx, Enbrel, and Humira.]
*DOCUMENTATION must be submitted which includes the following information: that the patient had previous trials and therapy failures with TWO preferred biological medications, OR that the patient has a medical contraindication to the use of the preferred medications. Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.

□ Yes □ No Patient had a previous trial and therapeutic failure with a preferred biological medication, or there is clinical evidence that the use of these agents would be medically contraindicated [Please Note the PREFERRED biologic medications are: Cosentyx, Enbrel, and Humira.]
*DOCUMENTATION must be submitted which includes the following information: that the patient had previous trials and therapy failures with a preferred biological or there is documented evidence that the use of these agents could be medically contraindicated. Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.

Plaque Psoriasis:

□ Yes □ No Patient has a diagnosis of plaque psoriasis

□ Yes □ No Patient had an inadequate response to phototherapy, systemic retinoids (oral isotretinoin), methotrexate, or cyclosporine or there is clinical evidence that the use of these agents would be medically contraindicated.
***DOCUMENTATION must be submitted which includes the following information:** the patient had an inadequate response to phototherapy, systemic retinoids (oral isotretinoin), methotrexate, or cyclosporine or there is clinical evidence that the use of these agents would be medically contraindicated. Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.

Ankylosing Spondylitis:

□ Yes □ No Patient has a diagnosis of ankylosing spondylitis

□ Yes □ No Patient had an inadequate response to at least TWO preferred non-steroidal anti-inflammatories (NSAIDs) at maximum therapeutic doses (trials should be at least three months in duration)

□ Yes □ No Patient has adverse responses or contraindications to NSAID use
***DOCUMENTATION must be submitted which includes the following information:** that there is clinical evidence that the use of the preferred non-steroidal anti-inflammatories (NSAIDs) would be medically contraindicated for this patient or the patient had trials and inadequate response to at least TWO preferred NSAIDs at maximum therapeutic doses (trials should be at least three months in duration). Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.

PLEASE NOTE: The Preferred NSAIDs are: diclofenac potassium, diclofenac sodium,

etodolac tab 400 mg, etodolac tab 500 mg, flurbiprofen, Ibuprofen Susp 100 MG/5ML, Ibuprofen tab 200 MG, ibuprofen tab 400 mg, ibuprofen tab 600 mg, ibuprofen tab 800 mg, indomethacin, ketoprofen, NAPROSYN SUSP, naproxen, naproxen sodium tab 550 mg, sulindac.

□ Yes □ No Patient has symptoms of peripheral arthritis

□ Yes □ No Patient failed a 30-day treatment trial with at least one conventional disease modifying antirheumatic drug (DMARD) [PLEASE NOTE: DMARDs include sulfasalazine and methotrexate]

□ Yes □ No Patient has a documented* adverse response or contraindication to DMARD use
PLEASE NOTE: DMARDs include sulfasalazine and methotrexate
***DOCUMENTATION must be submitted which includes the following information:** that there is clinical evidence that the use of the DMARD would be medically contraindicated for this patient**.** Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.

Rheumatoid Arthritis (RA):

□ Yes □ No Patient has a diagnosis of rheumatoid arthritis (RA)

□ Yes □ No Patient had a trial, and inadequate response to, TWO preferred disease modifying anti-rheumatic drugs (DMARDs) used concurrently.

□ Yes □ No Patient had a clinical evidence that the use of methotrexate and/or the preferred medications would be medically contraindicated for this patient. [PLEASE NOTE: The preferred DMARDs are hydroxycholoroquine, sulfasalazine, and leflunomide,]
*** DOCUMENTATION must be submitted which includes the following information:** that there is clinical evidence that the use of methotrexate and/or the preferred medications would be medically contraindicated for this patient. Documentation may include but is not limited to, chart notes, prescriptions claims records, prescription receipts, and laboratory data

□ Yes □ No Patient had an unsuccessful methotrexate trial

□ Yes □ No There evidence of severe disease documented by radiographic erosions

Moderate to Severe Psoriatic Arthritis:

□ Yes □ No Patient has a diagnosis of moderate to severe psoriatic arthritis

□ Yes □ No Patient had a trial and inadequate response to the preferred oral DMARD, methotrexate

□ Yes □ No Patient have a contraindication to the use of methotrexate
*** DOCUMENTATION must be submitted which includes the following information:** documented evidence that the use of the DMARD, methotrexate, is medically contraindicated. Documentation may include but is not limited to, chart notes, prescriptions claims records, prescription receipts, and laboratory data

□ Yes □ No Patient had a trial of leflunomide or sulfasalazine

□ Yes □ No Patient have a medical contraindication or clinical reason for not being able to use leflunomide or sulfasalazine
*** DOCUMENTATION must be submitted which includes the following information:** if there is a contraindication to methotrexate, then also the clinical reason this patient would not be able to use leflunomide or sulfasalazine instead. Documentation may include but is not limited to, chart notes, prescriptions claims records, prescription receipts, and laboratory data

Moderate to Severe Juvenile Idiopathic Arthritis:

□ Yes □ No Patient has a diagnosis of moderate to severe juvenile idiopathic arthritis

□ Yes □ No Patient has had a trial, and inadequate response to, intraarticular glucocorticoid injections

□ Yes □ No Patient have a contraindication to the use of intraarticular glucocorticoid injections
*** DOCUMENTATION must be submitted which includes the following information:** documented evidence that the use of the intraarticular glucocorticoid injections is medically contraindicated. Documentation may include but is not limited to, chart notes, prescriptions claims records,

prescription receipts, and laboratory data

□ Yes □ No Patient has had a trial, and inadequate response to, preferred oral DMARD, methotrexate

□ Yes □ No Patient have a contraindication to the use of methotrexate

*** DOCUMENTATION must be submitted which includes the following information:** documented evidence that the use of the preferred DMARD, methotrexate, is medically contraindicated. Documentation may include but is not limited to, chart notes, prescriptions claims records, prescription receipts, and laboratory data

□ Yes □ No Patient had a trial of leflunomide or sulfasalazine

□ Yes □ No Patient have a medical contraindication or clinical reason for not being able to use leflunomide or sulfasalazine

*** DOCUMENTATION must be submitted which includes the following information:** if there is a contraindication to methotrexate, then also the clinical reason this patient would not be able to use leflunomide or sulfasalazine instead. Documentation may include but is not limited to, chart notes, prescriptions claims records, prescription receipts, and laboratory data

Crohn's Disease:

□ Yes □ No Patient has a diagnosis of Crohn's Disease

□ Yes □ No Patient has a trial and inadequate response to TWO preferred conventional therapy including aminosalicylates (mesalamine, sulfasalazine), azathioprine/6-mercaptopurine, AND/OR methotrexate

□ Yes □ No Patient have a medical contraindication to TWO preferred conventional therapies

***DOCUMENTATION must be submitted which includes the following information:** that there is clinical evidence that the use of the preferred conventional therapy including aminosalicylates (mesalamine, sulfasalazine), azathioprine/6-mercaptopurine, AND/OR methotrexate would be medically contraindicated for this patient. Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.

Ulcerative Colitis (moderate to severe):

□ Yes □ No Patient has a diagnosis of ulcerative colitis (moderate to severe)

□ Yes □ No Patient has a trial and inadequate response to TWO preferred conventional therapies including aminosalicylates (mesalamine, sulfasalazine), and azathioprine/6-mercaptopurine

□ Yes □ No Patient have a medical contraindication to TWO preferred conventional therapies

***DOCUMENTATION must be submitted which includes the following information:** that there is clinical evidence that the use of the preferred conventional therapy including aminosalicylates (mesalamine, sulfasalazine), and azathioprine/6-mercaptopurine would be medically contraindicated for this patient. Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.

9. Physician signature

_____ _____

Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.