REMICADE/INFLECTRA/RENFLEXIS (INFLIXIMAB) [NON-PREFERRED] PRIOR AUTHORIZATION FORM

(form effective 1/1/20)

Keystone First | PERFORMRX℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-215-937-5018**, or to speak to a representative call **1-800-588-6767**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	# of pages:	Name of office contact:
Contact's phone number:		LTC facility contact/phone:

PATIENT INFORMATION

Patient name:	Patient ID #:	DOB:
Street address:	Apt. #:	City/state/zip:

PRESCRIBER INFORMATION

Prescriber name:	Specialty:	
State license #:	NPI:	MA Provider ID #
Street address:	Suite #:	City/state/zip:
Phone:	Fax:	

CLINICAL INFORMATION

Product requested: ☐ Inflectra 100 mg vial ☐ Remicade 100 mg vial ☐ Renflexis 100 mg vial			Dose & frequency:
# of vials:	Refills:	Dx code *(required)*:	Weight: _____ lbs / kg
Diagnosis *(submit documentation)*:			

PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):

Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Patient's Preferred Pharmacy Name:	
Pharmacy Phone #:	Pharmacy Fax #:
☐ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.	

INITIAL REQUESTS (Complete questions applicable to patient's diagnosis):

1. **All diagnoses:** Check all that apply to the patient and submit documentation for each.
   ☐ vaccinated for hepatitis B ☐ screened for tuberculosis ☐ screened for hepatitis B (surface antigen & core antibody) ☐ up-to-date with all age-appropriate immunizations
   ☐ has been using the requested infliximab product in the past 90 days

2. **All diagnoses**: Is the patient currently receiving therapy with an infliximab agent? ☐ Yes – *Submit documentation* ☐ No

3. **All diagnoses**: Does the patient have moderate or severe heart failure? ☐ Yes – *Submit documentation* ☐ No

4. **Ankylosing spondylitis or psoriatic arthritis**: Does the patient have a history of trial and failure, contraindication, or intolerance of the following?
   ☐ 4-week trial each of 2 different NSAIDs – list NSAIDs tried: _____ ☐ 8-week trial of methotrexate or other DMARD (does not apply to axial disease) list DMARDs tried:_____
   ☐ Cosentyx ☐Humira ☐ Enbrel
   ☐ Yes ☐ No *Submit documentation of all medications tried and outcomes.*

5. **Crohn's disease**: Does the patient have a history of trial and failure, contraindication, or intolerance of the following?
   ☐ aminosalicylates – list medications tried:_____ ☐ immunomodulators – list medications tried: _____
   ☐ corticosteroids – list medications tried:_____ ☐ Humira
   ☐ Yes ☐ No *Submit documentation of all medications tried and outcomes.*

6. **Ulcerative colitis:** Does the patient have a history of trial and failure, contraindication, or intolerance of the following?
   ☐ aminosalicylates – list medications tried: _____ ☐ immunomodulators – list medications tried: _____
   ☐ corticosteroids _ list medications tried: _____ ☐ Humira
   ☐ Yes ☐ No *Submit documentation of all medications tried and outcomes.*

7. **Rheumatoid arthritis**: Does the patient have a history of trial and failure, contraindication, or intolerance of the following medications? Check all that apply.
   ☐ 3 months of methotrexate or other DMARD ☐ Humira ☐Enbrel ☐Cosentyx
   list DMARDs tried: _____
   ☐ Yes ☐ No *Submit documentation of all medications tried and outcomes.*

8. **Plaque psoriasis**: Does at least one of the following apply to the patient?
   ☐ at least 5% of body surface area (BSA) is affected ☐ critical areas of the body are involved (face, palms, soles, and/or genitals)
   ☐ Yes ☐ No *Submit documentation.*

9. **Plaque psoriasis**: Does the patient have a history of trial and failure, contraindication, or intolerance of the following treatments and medications? Check all that apply.
   ☐ 3 months of PUVA ☐ acitretin ☐ 3 months of UVB light ☐ cyclosporine ☐ methotrexate ☐ Humira ☐ Cosentyx ☐ Enbrel
   ☐ Yes ☐ No *Submit documentation treatments tried and outcomes.*

10. **Uveitis**: Check all of the following that apply to the patient and submit documentation for each.
    ☐ has a diagnosis of uveitis associated with juvenile idiopathic arthritis or Behçet's disease
    ☐ has steroid-dependent uveitis (i.e., requires ≥ prednisone 7.5 mg daily [or equivalent]) with plan to taper or discontinue systemic steroids
    ☐ has a documented history of trial & failure, contraindication, or intolerance of systemic immunosuppressives or corticosteroids (systemic, topical, intraocular, or periocular) and Humira
    list medications tried: _____

11. **All other diagnoses:** Submit documentation supporting the use of infliximab for the patient's diagnosis & other treatments tried.

RENEWAL REQUESTS

1. Submit documentation of how the requested medication has helped the patient's condition and level of functioning.

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: