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

(form effective 1/5/21)

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 ☐ Avsola 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. <u>All diagnoses:</u> Check all that apply to the patient.
   ☐ vaccinated for hepatitis B ☐ screened for tuberculosis ☐ screened for hepatitis B (surface antigen & core antibody) ☐ up-to-date with all age-appropriate immunizations
2. <u>All diagnoses</u>: Is infliximab being prescribed by or in consultation with an appropriate specialist? ☐ Yes – *List specialty* _____ ☐ No
3. <u>All diagnoses</u>: If the request is for an infliximab product other than Avsola (infliximab-axxq), has member had either:
   ☐ a history of therapeutic failure, contraindication, or intolerance of Avsola (infliximab-axxq)
   ☐ a current history (within the past 90 days) of being prescribed the requested infliximab product
4. <u>All diagnoses</u>: Have all potential drug interactions been addressed? ☐ Yes ☐ No ☐ NA – no drug interactions exist
5. <u>All diagnoses</u>: Does the patient have a history of trial and failure, contraindication, or intolerance of the preferred Cytokine and CAM Antagonists approved or medically accepted for their condition? ☐ Yes ☐ *Enbrel* ☐ *Humira* ☐ *Taltz* ☐ No
6. <u>All diagnoses</u>: Is the patient currently (within the past 90 days) receiving therapy with an infliximab agent? ☐ Yes – *Submit documentation* ☐ No
7. <u>All diagnoses</u>: Does the patient have moderate or severe heart failure? ☐ Yes – *Submit documentation* ☐ No
8. <u>Ankylosing spondylitis</u>: Does the patient have a history of trial and failure of a two-week trial of continuous treatment with two different oral NSAIDs?
   ☐ Yes – list medications tried:_____
   ☐ No
9. <u>Psoriatic arthritis</u>: Does at least one of the following apply to the patient?
   ☐ axial disease and/or enthesitis and has tried and failed a two-week trial with two different oral NSAIDs; list medications tried:_____
   ☐ peripheral disease and has tried and failed methotrexate or other DMARD; list medications tried:_____
   ☐ severe disease
   ☐ concomitant moderate-to-severe nail disease
10. <u>Crohn's disease</u>: Does at least one of the following apply to the patient?
    ☐ moderate to severe Crohn's disease and one of the following
      ☐ failed to achieve remission with or has a contraindication or intolerance to an induction course of corticosteroids
      ☐ failed to maintain remission or has a contraindication or intolerance to immunomodulators
    ☐ has one or more high-risk or poor prognostic features
    ☐ has achieved remission with the requested medication and will be using the requested medication as maintenance therapy to maintain remission
11. <u>Ulcerative colitis:</u> check all that apply to the patient
    ☐ Mild UC that is associated with multiple poor prognostic factors
    ☐ Moderate-to-severe UC
    ☐ Failed to achieve remission with or has a contraindication or intolerance to an induction course of corticosteroids
    ☐ Failed to maintain remission or has a contraindication or intolerance to immunomodulators
    ☐ Has achieved remission with the requested medication and will be using the requested medication as maintenance therapy to maintain remission
12. <u>Rheumatoid arthritis</u>: Does the patient have a history of trial and failure, contraindication, or intolerance of at least three months of treatment with methotrexate or another non-biologic DMARD?
    ☐ Yes – list medications tried:_____
    ☐ No

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

13. Plaque psoriasis: Does at least one of the following apply to the patient?
- ☐ at least 3% of body surface area (BSA) is affected
- ☐ critical areas of the body are involved (face, palms, soles, and/or genitals)
- ☐ significant disability or impairment of physical or mental functioning
- ☐ Yes ☐ No Submit documentation.

14. Plaque psoriasis: Does the patient have a history of trial and failure, contraindication, or intolerance to the following? Check all that apply.
- ☐ oral systemic therapy – list medications tried:_____
- ☐ ultraviolet light therapy

15. Plaque psoriasis: Does the patient have a history of trial and failure, contraindication, or intolerance to topical corticosteroids or other topical therapy?
- ☐ Yes – list medications tried:_____
- ☐ No

16. 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); list medications tried: _____

17. 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.
2. Is infliximab being prescribed by or in consultation with an appropriate specialist?
   - ☐ Yes – list specialty:_____
   - ☐ No
3. Have all potential drug interactions been addressed?
   - ☐ Yes
   - ☐ No
   - ☐ NA – no drug interactions exist

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: