

# REMICADE/INFLECTRA/RENFLIXIS (INFLIXIMAB) [NON-PREFERRED]

## PRIOR AUTHORIZATION FORM

(form effective 1/1/20)



Fax to PerformRx<sup>SM</sup> at **1-888-981-5202**, or to speak to a representative call **1-866-610-2774**.

### PRIOR AUTHORIZATION REQUEST INFORMATION

<input type="checkbox"/> New request <input type="checkbox"/> 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

<b>Product requested:</b> <input type="checkbox"/> Inflectra 100 mg vial <input type="checkbox"/> Remicade 100 mg vial <input type="checkbox"/> Renflexis 100 mg vial	Dose & frequency:		
# of vials:	Refills:	Dx code ( <i>required</i> ):	Weight: _____ lbs / kg
Diagnosis ( <i>submit documentation</i> ):			

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

Deliver to: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Preferred Pharmacy Name:	
Pharmacy Phone #:	Pharmacy Fax #:
<input type="checkbox"/> I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.	

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

- 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
- All diagnoses:** Is the patient currently receiving therapy with an infliximab agent?  Yes – *Submit documentation*     No
- All diagnoses:** Does the patient have moderate or severe heart failure?  Yes – *Submit documentation*     No
- 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)  
 Cosentyx     Humira     Enbrel    list DMARDs tried: \_\_\_\_\_  
 Yes     No    *Submit documentation of all medications tried and outcomes.*
- 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.*
- 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.*
- 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.*
- 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.*
- 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.*
- 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: \_\_\_\_\_
- 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:
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