# REMICADE/INFLECTRA/RENFLEXIS/ AVSOLA/INFLIXIMAB PRIOR AUTHORIZATION FORM

(form effective 1/9/2023)

Keystone First Community HealthChoices | PERFORMRX℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-855-851-4058**, or to speak to a representative call **1-866-907-7088**.

## 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:**
☐ Avsola (preferred) ☐ Infliximab (preferred) ☐ Inflectra (non-preferred) ☐ Remicade (non-preferred) ☐ Renflexis (non-preferred)

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.
   ☐ screened for tuberculosis ☐ screened for hepatitis B (anti-HBs, HBsAg, and anti-HBc)
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, for a non-preferred agent</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? Check all that apply.
   ☐ Avsola ☐ Actemra syringe/vial ☐ Enbrel ☐ Humira ☐ Infliximab (generic Remicade) ☐ Kineret ☐ Orencia ☐ Otezla ☐ Simponi pen/syringe
   ☐ Taltz ☐ Xeljanz tablet
4. <u>All diagnoses</u>: Is the patient currently (within the past 90 days) receiving therapy with the requested infliximab agent? ☐ Yes – *Submit documentation* ☐ No
5. <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 – provide explanation:_____
6. <u>Psoriatic arthritis</u>: Does at least one of the following apply to the patient?
   ☐ axial disease, dactylitis, and/or enthesitis
   ☐ has tried and failed methotrexate or other DMARD for at least 8 weeks; list medications tried or explain contraindication:_____
   ☐ severe disease
   ☐ concomitant moderate-to-severe nail disease
   ☐ concomitant active inflammatory bowel disease
7. <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 a conventional immunomodulator
   ☐ 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
8. <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 a conventional immunomodulator
   ☐ Has achieved remission with the requested medication and will be using the requested medication as maintenance therapy to maintain remission
9. <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 – provide explanation:_____

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

**10.** Chronic psoriasis: Check all that apply.
- ☐ at least 3% of body surface area (BSA) is affected
- ☐ critical areas of the body are involved (such as face, palms, soles, and/or genitals)
- ☐ significant disability or impairment of physical, mental, or psychosocial functioning
- ☐ moderate to severe nail disease
- ☐ history of therapeutic failure, contraindication or intolerance to (check all that apply):
  - ☐ 4-week trial of topical steroids or 8-week trial of other topical therapy; list medications tried or explain contraindication: _____
  - ☐ 3-month trial of conventional systemic therapy; list medications tried or explain contraindication: _____
  - ☐ phototherapy

**11.** 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: _____

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

## RENEWAL REQUESTS

1. Since starting infliximab, has the patient experienced improvement in disease activity and/or level of functioning?
   - ☐ Yes
   - ☐ No
2. Is infliximab being prescribed by or in consultation with an appropriate specialist?
   - ☐ Yes – list specialty:_____
   - ☐ No

## PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

| Prescriber signature: | Date: |
|---|---|