

SENTARA COMMUNITY PLAN (MEDICAID)

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-844-305-2331**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed.**

Infliximab Category (Medical)

Drug Requested: (Select drug below)

NON-PREFERRED		
Trial and failure of 2 preferred biologics plus trial and failure of infliximab (unbranded Remicade) prior to use of any other infliximab product is required.		
<input type="checkbox"/> Avsola™ (infliximab- axxq) (Q5121) 100 mg/ml; 1 vial=10 billable units	<input type="checkbox"/> Inflectra® (infliximab- dyyb) (Q5103) 100 mg/ml; 1 vial=10 billable units	<input type="checkbox"/> Infliximab (J1745) (unbranded Remicade) NDC (57894-0160-01) 100 mg/ml; 1 vial=10 billable units
<input type="checkbox"/> Remicade® (infliximab) (J1745) NDC (57894-0030-01) 100 mg/ml; 1 vial=10 billable unit	<input type="checkbox"/> Renflexis® (infliximab-abda) (Q5104) 100 mg/ml; 1 vial=10 billable units	<input type="checkbox"/> Zymfentra™ (infliximab-dyyb) (J1748) <small>*(Refer to Zymfentra Pharmacy PA form)</small>

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight (if applicable): _____ Date weight obtained: _____

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- Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

DIAGNOSIS	Recommended Dose
<input type="checkbox"/> Ankylosing Spondylitis (AS) Dosing: _____	<ul style="list-style-type: none"> • 5mg/kg at week 0, 2 and 6, then every 6 weeks thereafter
<input type="checkbox"/> Crohn's Disease (CD) Dosing: _____	<ul style="list-style-type: none"> • 5mg/kg at week 0, 2 and 6, then every 8 weeks thereafter. Max dose 10mg/kg every 8 weeks
<input type="checkbox"/> Pediatric Crohn's Disease (CD) Age ≥ 6 years Dosing: _____	<ul style="list-style-type: none"> • 5mg/kg at week 0, 2 and 6 weeks, then every 8 weeks thereafter
<input type="checkbox"/> Plaque Psoriasis (Ps) Dosing: _____	<ul style="list-style-type: none"> • 5mg/kg at week 0, 2 and 6, then every 8 weeks thereafter
<input type="checkbox"/> Psoriatic Arthritis (PsA) Dosing: _____	<ul style="list-style-type: none"> • 5mg/kg at week 0, 2 and 6, then every 8 weeks thereafter
<input type="checkbox"/> Rheumatoid Arthritis (RA) in combination with methotrexate Dosing: _____	<ul style="list-style-type: none"> • 3mg/kg at week 0, 2 and 6, then every 8 weeks thereafter. Max dose 10mg/kg every 8 weeks or 3mg/kg every 4 weeks
<input type="checkbox"/> Ulcerative Colitis (UC) Dosing: _____	<ul style="list-style-type: none"> • 5mg/kg at week 0, 2 and 6, then every 8 weeks thereafter
<input type="checkbox"/> Pediatric Ulcerative Colitis Age ≥ 6 years Dosing: _____	<ul style="list-style-type: none"> • 5mg/kg at week 0, 2 and 6, then every 8 weeks thereafter
<input type="checkbox"/> Ocular Sarcoidosis Dosing: _____	<ul style="list-style-type: none"> • 3 to 5 mg/kg at weeks 0, 2, and 6, followed by • 3 to 5 mg/kg every 4 to 8 weeks thereafter

CLINICAL CRITERIA: Check below all that apply. All criteria/diagnosis must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied. If requesting an increase in dose, recent lab values and symptoms documenting active disease must be submitted with request.

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- Has the member been approved for Infliximab, Avsola, Inflectra, Remicade or Renflexis previously through the Sentara pharmacy department? Yes No

Member must meet FDA approved age and indication for coverage

Diagnosis: Rheumatoid Arthritis

- Diagnosed for **Rheumatoid Arthritis**
- Infliximab (Remicade®):**
 - Member has tried and failed **BOTH** of the preferred drugs below:

<input type="checkbox"/> adalimumab-adbm (Boehringer Ingelheim) OR Hadlima® (adalimumab-bwwd)	<input type="checkbox"/> Enbrel®
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- Avsola®, Inflectra®, Remicade® or Renflexis®:**
 - Member has tried and failed **BOTH** of the preferred drugs below:

<input type="checkbox"/> adalimumab-adbm (Boehringer Ingelheim) OR Hadlima® (adalimumab-bwwd)	<input type="checkbox"/> Enbrel®
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- Member has tried and failed infliximab (Remicade®) therapy

Diagnosis: Psoriatic Arthritis

- Diagnosed for **Psoriatic Arthritis**
- Infliximab (Remicade®):**
 - Member has tried and failed **TWO (2)** of the preferred drugs below:

<input type="checkbox"/> adalimumab-adbm (Boehringer Ingelheim) OR Hadlima® (adalimumab-bwwd)	<input type="checkbox"/> Enbrel®	<input type="checkbox"/> Pyzchiva® syringe/vial OR Starjemza™ (Requires trial and failure of a preferred TNF-alpha inhibitor)
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- Avsola®, Inflectra®, Remicade® or Renflexis®:**
 - Member has tried and failed **TWO (2)** of the preferred drugs below:

<input type="checkbox"/> adalimumab-adbm (Boehringer Ingelheim) OR Hadlima® (adalimumab-bwwd)	<input type="checkbox"/> Enbrel®	<input type="checkbox"/> Pyzchiva® syringe/vial OR Starjemza™ (Requires trial and failure of a preferred TNF-alpha inhibitor)
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- Member has tried and failed infliximab (Remicade®) therapy

❑ Diagnosis: Ankylosing Spondylitis

- ❑ Diagnosed for **active ankylosing spondylitis**
- ❑ **Infiximab (Remicade®):**
 - ❑ Member has tried and failed **BOTH** of the preferred drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) OR Hadlima® (adalimumab-bwwd)	❑ Enbrel®
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- ❑ **Avsola®, Inflectra®, Remicade® or Renflexis®:**
 - ❑ Member has tried and failed **BOTH** of the preferred drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) OR Hadlima® (adalimumab-bwwd)	❑ Enbrel®
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- ❑ Member has tried and failed infiximab (Remicade®) therapy

❑ Diagnosis: Plaque Psoriasis

- ❑ Diagnosed for **Plaque Psoriasis**
- ❑ **Infiximab (Remicade®):**
 - ❑ Member has tried and failed **TWO (2)** of the preferred drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) OR Hadlima® (adalimumab-bwwd)	❑ Enbrel®	❑ Pyzchiva® syringe/vial OR Starjemza™ (Requires trial and failure of a preferred TNF-alpha inhibitor)
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- ❑ **Avsola®, Inflectra®, Remicade® or Renflexis®:**
 - ❑ Member has tried and failed **TWO (2)** of the preferred drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) OR Hadlima® (adalimumab-bwwd)	❑ Enbrel®	❑ Pyzchiva® syringe/vial OR Starjemza™ (Requires trial and failure of a preferred TNF-alpha inhibitor)
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- ❑ Member has tried and failed infiximab (Remicade®) therapy

❑ Diagnosis: Crohn's Disease - moderate to severe

- ❑ Diagnosed for **Crohn's Disease**
- ❑ Member is 6 years of age or older for diagnosis of Crohn's disease

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Infliximab (Remicade®):

- Member has tried and failed **BOTH** of the preferred drugs below:

<input type="checkbox"/> adalimumab-adbm (Boehringer Ingelheim) OR Hadlima® (adalimumab-bwwd)	<input type="checkbox"/> Pyzchiva® syringe/vial OR Starjemza™ (Requires trial and failure of a preferred TNF-alpha inhibitor)
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Avsola®, Inflectra®, Remicade® or Renflexis®:

- Member has tried and failed **BOTH** of the preferred drugs below:

<input type="checkbox"/> adalimumab-adbm (Boehringer Ingelheim) OR Hadlima® (adalimumab-bwwd)	<input type="checkbox"/> Pyzchiva® syringe/vial OR Starjemza™ (Requires trial and failure of a preferred TNF-alpha inhibitor)
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- Member has tried and failed infliximab (Remicade®) therapy

Diagnosis: Ulcerative Colitis - moderate to severe

- Diagnosed for **Ulcerative Colitis**

- Member is 6 years of age or older for diagnosis of Ulcerative Colitis

Infliximab (Remicade®):

- Member has tried and failed **BOTH** of the preferred drugs below:

<input type="checkbox"/> adalimumab-adbm (Boehringer Ingelheim) OR Hadlima® (adalimumab-bwwd)	<input type="checkbox"/> Pyzchiva® syringe/vial OR Starjemza™ (Requires trial and failure of a preferred TNF-alpha inhibitor)
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Avsola®, Inflectra®, Remicade® or Renflexis®:

- Member has tried and failed **BOTH** of the preferred drugs below:

<input type="checkbox"/> adalimumab-adbm (Boehringer Ingelheim) OR Hadlima® (adalimumab-bwwd)	<input type="checkbox"/> Pyzchiva® syringe/vial OR Starjemza™ (Requires trial and failure of a preferred TNF-alpha inhibitor)
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- Member has tried and failed infliximab (Remicade®) therapy

Diagnosis: Ocular Sarcoidosis

- Diagnosed for **Ocular Sarcoidosis**

Infliximab (Remicade®):

- Member has tried and failed **ONE (1)** of the preferred drugs below:

<input type="checkbox"/> adalimumab-adbm (Boehringer Ingelheim)	<input type="checkbox"/> Hadlima® (adalimumab-bwwd)
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Avsola®, Inflectra®, Remicade® or Renflexis®:

Member has tried and failed **ONE (1)** of the preferred drugs below:

<input type="checkbox"/> adalimumab-adbm (Boehringer Ingelheim)	<input type="checkbox"/> Hadlima® (adalimumab-bwwd)
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Member has tried and failed infliximab (Remicade®) therapy

Medication being provided by: Please check applicable box below.

Location/site of drug administration: _____

NPI or DEA # of administering location: _____

OR

Specialty Pharmacy – PropriumRx

For urgent reviews: Practitioner should call Sentara Health Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health’s definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member’s ability to regain maximum function.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****