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)

PREFERRED		
❑ **Infliximab (JI745)** NDC (57894-0160-01) 100mg/ml; 1 vial=10 billable units		
NON-PREFERRED		
❑ **Avsola™** (infliximab- axxq) **(Q5121)** 100mg/ml; 1 vial=10 billable units	❑ **Inflectra®** (infliximab- dyyb) **(Q5103)** 100mg/ml; 1 vial=10 billable units	❑ **Remicade®** (infliximab) **(J1745)** NDC (57894-0030-01) 100mg/ml; 1 vial=10 billable units
❑ **Renflexis®** (infliximab- abda) **(Q5104)** 100mg/ml; 1 vial=10 billable units	❑ **Zymfentra™** (infliximab-dyyb)* **(J1748)** ***(Refer to Zymfentra Pharmacy PA form)**	

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.
  - **Effective July 1, 2023 per DMAS Infliximab is the preferred infliximab product. Remicade®, Inflectra®, Avsola®, Renflexis®, Zymfentra™ are non-preferred.**
  - If requesting preferred drug, Infliximab: please check diagnosis and enter the dosing below that applies. No additional prior authorization criteria is required.
  - **If requesting a non-preferred drug, Renflexis®, Remicade®, Inflectra® , Avsola® or Zymfentra™ please complete all of the required prior authorization criteria.**

DIAGNOSIS	Recommended Dose
❑ **Ankylosing Spondylitis (AS)** Dosing: _____	• 5mg/kg at week 0, 2 and 6, then every 6 weeks thereafter
❑ **Crohn's Disease (CD)** Dosing: _____	• 5mg/kg at week 0, 2 and 6, then every 8 weeks thereafter. Max dose 10mg/kg every 8 weeks
❑ **Pediatric Crohn's Disease (CD) Age ≥ 6 years** Dosing: _____	• 5mg/kg at week 0, 2 and 6 weeks, then every 8 weeks thereafter
❑ **Plaque Psoriasis (Ps)** Dosing: _____	• 5mg/kg at week 0, 2 and 6, then every 8 weeks thereafter
❑ **Psoriatic Arthritis (PsA)** Dosing: _____	• 5mg/kg at week 0, 2 and 6, then every 8 weeks thereafter
❑ **Rheumatoid Arthritis (RA) in combination with methotrexate** Dosing: _____	• 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
❑ **Ulcerative Colitis (UC)** Dosing: _____	• 5mg/kg at week 0, 2 and 6, then every 8 weeks thereafter
❑ **Pediatric Ulcerative Colitis Age ≥ 6 years** Dosing: _____	• 5mg/kg at week 0, 2 and 6, then every 8weeks 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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❑ Diagnosis: Rheumatoid Arthritis or Psoriatic Arthritis

❑ Check diagnosis:

❑ **Rheumatoid Arthritis** **OR** ❑ **Psoriatic Arthritis**

AND

❑ Prescriber is a **Rheumatologist**

AND

❑ Trial and failure of **ONE** of the **PREFERRED** drugs below:

❑ azathioprine	❑ hydroxychloroquine	❑ 6-mercaptopurine	❑ methotrexate
❑ leflunomide	❑ aminosalicylates	❑ auranofin	❑ sulfasalazine
❑ Other: _____			

AND

❑ Trial and failure to Humira® or Enbrel® **AND** Infliximab therapy

❑ Diagnosis: Ankylosing Spondylitis

❑ Diagnosed for **active ankylosing spondylitis**

AND

❑ Prescribed by or in consultation with a **Rheumatologist**

AND

❑ Trial and failure, contraindication, or intolerance to **TWO** NSAIDs

AND

❑ Trial and failure of **ONE** of the **PREFERRED** drugs below:

❑ Humira®	❑ Enbrel®

AND

❑ Trial and failure to Infliximab therapy

❑ Diagnosis: Plaque Psoriasis

❑ Diagnosed for **Plaque Psoriasis**

AND

❑ Prescribed by or in consultation with a Dermatologist

AND

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- ❑ Trial and failure of **ONE** of the **PREFERRED** drugs below:

❑ acitretin	❑ cyclosporine	❑ methotrexate

AND

- ❑ Trial and failure to Humira® or Enbrel® **AND** Infliximab therapy

❑ Diagnosis: Crohn's Disease OR Ocular Sarcoidosis - moderate to severe with inadequate response to:

- ❑ Diagnosed for:
  - ❑ **Crohn's Disease** **OR** ❑ **Ocular Sarcoidosis**

AND

- ❑ Prescribed by or in consultation with a **Gastroenterologist**

OR

- ❑ Prescribed by or in consultation with an **Ophthalmologist**

AND

- ❑ Inadequate response to high dose steroids (e.g.,40-60 mg prednisone)

AND

- ❑ Trial and failure of **ONE** of the **PREFERRED** drugs below:

❑ azathioprine	❑ hydroxychloroquine	❑ 6-mercaptopurine	❑ methotrexate
❑ leflunomide	❑ aminosalicylates	❑ auranofin	❑ sulfasalazine
❑ Other: _____			

AND

- ❑ Trial and failure to Humira® **AND** Infliximab therapy for Crohn's disease indication

❑ Diagnosis: Moderate-to-severe Ulcerative Colitis disease

- ❑ Diagnosed for moderate-to-severe **Ulcerative Colitis**

AND

- ❑ Prescribed by or in consultation with a **Gastroenterologist**

AND

- ❑ Inadequate response to high dose steroids (e.g.40-60 mg prednisone)

AND

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- ❑ Trial and failure of **ONE** of the **PREFERRED** drugs below:

❑ azathioprine	❑ hydroxychloroquine	❑ 6-mercaptopurine	❑ methotrexate
❑ leflunomide	❑ aminosalicylates	❑ auranofin	❑ sulfasalazine
❑ Other: _____			

AND

- ❑ Trial and failure to Humira® **AND** Infliximab therapy

Medication being provided by (check below that applies):

- ❑ **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.****

***Approved by Pharmacy & Therapeutic Committee:** ~~10/18/2018;~~ **7/16/2020**
REVISED/UPDATED/REFORMATTED: ~~12/30/2018; 3/16/2019; 7/7/2019; 9/28/2019; 11/11/2019; 11/12/2020; 4/1/2021; 6/14/2021; 7/19/2021; 2/17/2022;7/8/2022; 6/20/2023; 7/12/2023; 11/7/2023; 6/19/2024;~~ **7/31/2024**