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		
❑ **adalimumab-adbm** (Boehringer Ingelheim) **OR Hadlima®** (adalimumab-bwwd)	❑ **Enbrel®** (etanercept)	❑ **Pyzchiva®syringe/vial** (Requires trial and failure of a preferred TNF-alpha inhibitor)
NON-PREFERRED **Trial and failure of 2 preferred biologics plus trial and failure of infliximab (generic Remicade) prior to use of any other infliximab product is required.**		
❑ **Avsola™** (infliximab- axxq) **(Q5121)** 100 mg/ml; 1 vial=10 billable units	❑ **Inflectra®** (infliximab- dyyb) **(Q5103)** 100 mg/ml; 1 vial=10 billable units	❑ **Infliximab (J1745)** NDC (57894-0160-01) 100 mg/ml; 1 vial=10 billable units
❑ **Remicade®** (infliximab) **(J1745)** NDC (57894-0030-01) 100 mg/ml; 1 vial=10 billable unit	❑ **Renflexis®** (infliximab-abda) **(Q5104)** 100 mg/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 #: _____

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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:** _____

❑ 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
❑ **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 8 weeks thereafter
❑ **Ocular Sarcoidosis** Dosing: _____	• 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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❑ Diagnosis: Rheumatoid Arthritis

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

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Enbrel®

- ❑ **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®

  - ❑ 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:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Enbrel®	❑ Pyzchiva® syringe/vial (Requires trial and failure of a preferred TNF-alpha inhibitor)

- ❑ **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 (Requires trial and failure of a preferred TNF-alpha inhibitor)

  - ❑ Member has tried and failed infliximab (Remicade®) therapy

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❑ Diagnosis: Ankylosing Spondylitis

- ❑ Diagnosed for **active ankylosing spondylitis**
- ❑ **Infliximab (Remicade®):**
  - ❑ Member has tried and failed **TWO (2)** of the preferred drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Enbrel®

- ❑ **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®

  - ❑ Member has tried and failed infliximab (Remicade®) therapy

❑ Diagnosis: Plaque Psoriasis

- ❑ Diagnosed for **Plaque Psoriasis**
- ❑ **Infliximab (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 (Requires trial and failure of a preferred TNF-alpha inhibitor)

- ❑ **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 (Requires trial and failure of a preferred TNF-alpha inhibitor)

  - ❑ Member has tried and failed infliximab (Remicade®) therapy

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

❑ adalimumab-adbm (Boehringer Ingelheim) OR Hadlima® (adalimumab-bwwd)	❑ Pyzchiva® syringe/vial (Requires trial and failure of a preferred TNF-alpha inhibitor

- ❑ **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)	❑ Pyzchiva® syringe/vial (Requires trial and failure of a preferred TNF-alpha inhibitor

  - ❑ 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 **TWO (2)** of the preferred drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) OR Hadlima® (adalimumab-bwwd)	❑ Pyzchiva® syringe/vial (Requires trial and failure of a preferred TNF-alpha inhibitor

- ❑ **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)	❑ Pyzchiva® syringe/vial (Requires trial and failure of a preferred TNF-alpha inhibitor

  - ❑ Member has tried and failed infliximab (Remicade®) therapy

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❑ Ocular Sarcoidosis

- ❑ Diagnosed for **Ocular Sarcoidosis**
- ❑ **Infliximab (Remicade®):**
  - ❑ Member has tried and failed **ONE (1)** of the preferred drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim)	❑ Hadlima® (adalimumab-bwwd)

- ❑ **Avsola®, Inflectra®, Remicade® or Renflexis®:**
  - ❑ Member has tried and failed **TWO (2)** of the preferred drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim)	❑ Hadlima® (adalimumab-bwwd)

  - ❑ 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.

***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; 10/17/2025;~~ **12/13/2025**