SENTARA HEALTH PLANS

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 1-844-668-1550**. 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**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Infliximab Category (MEDICAL)

PREFERRED			
❑ **Renflexis®** (infliximab-abda) **(Q5104)**			
NON-PREFERRED			
❑ **Avsola™** (infliximab-axxq) **(Q5121)**	❑ **Inflectra®** (infliximab-dyyb) **(Q5103)**	❑ **Infliximab (JI745)**	❑ **Remicade®** (infliximab) **(J1745)**

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:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

- **Renflexis® is the preferred infliximab product. Remicade®, Avsola™, Inflectra® & Infliximab are non-preferred.**
- **For new and renewal authorizations, members are required to use the preferred product, Renflexis®, unless contraindicated.**

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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.

Avsola™, Inflectra®, Infliximab & Remicade® must have trial and failure of Renflexis®

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.

❑ Diagnosis: Rheumatoid Arthritis or Psoriatic Arthritis

Recommended Dosage:

- **Rheumatoid Arthritis Dosing IV:** 3 mg/kg at 0, 2, and 6 weeks, followed by a maintenance regimen of 3 mg/kg every 8 weeks
- **Psoriatic Arthritis Dosing:** 5 mg/kg at 0, 2, and 6 weeks, followed by 5 mg/kg every 8 weeks

❑ Check diagnosis:

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

AND

❑ Prescriber is a **Rheumatologist**

AND

❑ Tried and failed **at least one DMARD** therapy for **at least three (3) months**:

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

❑ Diagnosis: Ankylosing Spondylitis

Recommended Dosage:

- 5 mg/kg at 0, 2, and 6 weeks, followed by 5 mg/kg every 6 weeks

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

AND

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

AND

❑ **Remicade® or Infliximab only**: Trial and failure or intolerance to Inflectra® **AND** Renflexis®

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❑ Diagnosis - Plaque Psoriasis

Recommended Dosage:
- 5 mg/kg at 0, 2, and 6 weeks, followed by 5 mg/kg every 8 weeks

❑ Prescribed by or in consultation with a Dermatologist

AND

❑ Member's Psoriasis involves: palms, soles, face, genitalia, or greater than 10% of total body surface area
❑ Yes **OR** ❑ No

AND

❑ Member tried and failed either Phototherapy or Alternative Systemic therapy for **at least three (3) months (check each tried):**

❑ **Phototherapy** **OR** ❑ **Alternative Systemic therapy**

❑ UV Light Therapy	❑ Oral Alternative Systemic Therpay
❑ NB UV-B	❑ acitretin
❑ PUVA	❑ methotrexate
	❑ cyclosporine

❑ Diagnosis - Crohn's Disease or Ocular Sarcoidosis

Recommended Dosage:
- **Crohn's Disease:** 5 mg/kg at 0, 2, and 6 weeks, followed by 5 mg/kg every 8 weeks

❑ Check diagnosis:

❑ **Crohn's Disease** **OR** ❑ **Ocular Sarcoidosis**

AND

❑ Tried and failed **at least one DMARD** therapy for **at least three (3) months**

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

AND

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

OR

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

AND

❑ Inadequate response to: budesonide or high dose steroids (40-60 mg prednisone)

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❑ **Diagnosis: Moderate-to-severe Ulcerative Colitis disease**
Recommended Dosage: • 5 mg/kg at 0, 2, and 6 weeks, followed by 5 mg/kg every 8 weeks

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

AND

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

AND

❑ Tried and failed **at least one DMARD** therapy for **at least three (3) months**

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

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 Plans Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health Plan'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
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