# 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 Products (MEDICAL)

| PREFERRED | |
|---|---|
| ❑ **Renflexis®** (infliximab-abda) **(Q5104)** | ❑ **Infliximab (JI745)** |

| NON-PREFERRED | | | |
|---|---|---|---|
| ❑ **Avsola™** (infliximab-axxq) **(Q5121)** | ❑ **Inflectra®** (infliximab-dyyb) **(Q5103)** | ❑ **Remicade®** (infliximab) **(J1745)** | ❑ **Zymfentra™** (infliximab-dyyb) **SQ (J1748)** |

**NOTE: Zymfentra is only FDA approved for maintenance treatment of moderately to severely active Crohn's disease or ulcerative colitis following treatment with an infliximab product administered intravenously**

**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:** _____

❑ 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.

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

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

❑ Member has a diagnosis of **ONE** of the following
- ❑ Rheumatoid Arthritis
- ❑ Psoriatic Arthritis

**AND**

❑ Medication must be prescribed by or in consultation with a **Rheumatologist**

**AND**

❑ Member tried and failed at least **one (1) DMARD** therapy for at least **three (3) months** **(check each tried below)**:

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

**AND**

❑ **For non-preferred infliximab product requests (e.g., Avsola™, Inflectra® & Remicade®):** Member must have trial and failure or intolerance to preferred Renflexis® and unbranded Infliximab

## ❑ Diagnosis: Ankylosing Spondylitis

**Recommended Dosage:**

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

❑ Medication must be prescribed by or in consultation with a **Rheumatologist**

**AND**

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- ❑ Member must have a trial and failure, contraindication, or intolerance to **TWO** NSAIDs

**AND**

- ❑ **For non-preferred infliximab product requests (e.g., Avsola™, Inflectra® & Remicade®):** Member must have trial and failure or intolerance to preferred Renflexis® and unbranded Infliximab

## ❑ Diagnosis - Plaque Psoriasis

**Recommended Dosage:**

- IV – 5 mg/kg at 0, 2, and 6 weeks, followed by 5 mg/kg every 8 weeks

- ❑ Medication must be prescribed by or in consultation with a **Dermatologist**

**AND**

- ❑ Member's psoriasis must involve palms, soles, face, genitalia, or greater than 10% of total body surface area

**AND**

- ❑ Member tried and failed at least **ONE** of either Phototherapy or Alternative Systemic Therapy for at least **three (3) months** **(check each tried below)**:

| ❑ **Phototherapy:** | ❑ **Alternative Systemic Therapy:** |
|---|---|
| ❑ **UV Light Therapy**<br>❑ NB UV-B<br>❑ PUVA | ❑ **Oral Medications**<br>❑ acitretin<br>❑ methotrexate<br>❑ cyclosporine |

**AND**

- ❑ **For non-preferred infliximab product requests (e.g., Avsola™, Inflectra® & Remicade®):** Member must have trial and failure or intolerance to preferred Renflexis® and unbranded Infliximab

## ❑ Diagnosis - Ocular Sarcoidosis

**Recommended Dosage:**

- **Ocular Sarcoidosis:** IV – 3 to 5 mg/kg at weeks 0, 2, and 6, followed by 3 to 5 mg/kg every 4 to 8 weeks thereafter

- ❑ Medication must be prescribed by or in consultation with an **Ophthalmologist**

**AND**

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- ❑ Member tried and failed at least **one (1) DMARD** therapy for at least **three (3) months** **(check each tried below)**:

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

**AND**

- ❑ Member must have a trial and failure or inadequate response to budesonide or high dose steroids (40-60 mg prednisone)

**AND**

- ❑ **For non-preferred infliximab product requests (e.g., Avsola™, Inflectra® & Remicade®):** Member must have trial and failure or intolerance to preferred Renflexis® and unbranded Infliximab

## ❑ Diagnosis: Moderate-to-Severe Crohn's Disease (CD) or Ulcerative Colitis (UC)

**Recommended Dosage:**

- IV – 5 mg/kg at 0, 2, and 6 weeks, followed by 5 mg/kg every 8 weeks
- **SQ Zymfentra** – 120 mg subcutaneously once every two weeks starting at week 10 and thereafter, following treatment with an infliximab product administered intravenously

**NOTE: Zymfentra is only FDA approved for maintenance treatment of moderately to severely active Crohn's disease or ulcerative colitis following treatment with an infliximab product administered intravenously. All requests for SQ maintenance administration of Zymfentra will need to be submitted & billed under the pharmacy benefit.**

- ❑ Member has a diagnosis of **ONE** of the following
  - ❑ Crohn's Disease
  - ❑ Ulcerative Colitis

**AND**

- ❑ Medication must be prescribed by or in consultation with a **Gastroenterologist**

**AND**

- ❑ Member tried and failed at least **one (1) DMARD** therapy for at least **three (3) months** **(check each tried below)**:

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

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**AND**

- ❑ Member must have a trial and failure or inadequate response to budesonide or high dose steroids (40-60 mg prednisone)

**AND**

- ❑ **For non-preferred infliximab product requests (e.g., Avsola™, Inflectra®, Remicade®& Zymfentra®):** Member must have trial and failure or intolerance to preferred Renflexis® and unbranded Infliximab

**Medication being provided by: Please check applicable box below.**

- ❑ **Location/site of drug administration:** _____

  **NPI or DEA # of administering location:** _____

**OR**

- ❑ **Specialty Pharmacy**

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; 11/21/2024;~~ **3/27/2025**
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