SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY 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 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Infliximab Category (Pharmacy)

Drug Requested: (Select drug below)

PREFERRED		
❑ **Infliximab NDC (57894-0160-01)**		
NON-PREFERRED		
❑ **Avsola™** (infliximab- axxq) *requires authorization under medical benefit	❑ **Inflectra®** (infliximab- dyyb) *requires authorization under medical benefit	❑ **Remicade®** (infliximab) NDC (57894-0030-01)
❑ **Renflexis®** (infliximab-abda)	❑ **Zymfentra™** (infliximab- dyyb)* ***(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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- **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.

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

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❑ Diagnosis: Rheumatoid Arthritis or Psoriatic Arthritis

- ❑ Check diagnosis:
  - ❑ **Rheumatoid Arthritis** **OR** ❑ **Psoriatic Arthritis**
- ❑ Trial and failure to **ONE** of the preferred drugs below:

❑ Humira®	❑ Enbrel®

- ❑ Trial and failure to infliximab therapy

❑ Diagnosis: Ankylosing Spondylitis

- ❑ Diagnosed for **active ankylosing spondylitis**
- ❑ Trial and failure of **ONE** of the preferred drugs below:

❑ Humira®	❑ Enbrel®

- ❑ Trial and failure to infliximab therapy

❑ Diagnosis: Plaque Psoriasis

- ❑ Diagnosed for **Plaque Psoriasis**
- ❑ Trial and failure of **ONE** of the preferred drugs below:

❑ Humira®	❑ Enbrel®

- ❑ Trial and failure to infliximab therapy

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

- ❑ Diagnosed for:
  - ❑ **Crohn's Disease** **OR** ❑ **Ocular Sarcoidosis**
- ❑ Member is 6 years of age or older for diagnosis of Crohn's disease
- ❑ Trial and failure of **ONE** the preferred drugs below:

❑ Humira®	❑ Enbrel®

- ❑ Trial and failure to infliximab therapy for Crohn's disease indication

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❑ Diagnosis: Moderate-to-severe Ulcerative Colitis disease

- ❑ Diagnosed for moderate-to-severe **Ulcerative Colitis**
- ❑ Member is 6 years of age or older
- ❑ Trial and failure of **BOTH** of the preferred biologics below:

❑ Humira®	❑ Infliximab

Medication being provided by: Please check applicable box below.

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

NPI or DEA # of administering location: _____

OR

❑ **Specialty Pharmacy – PropriumRx**

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; 6/07/2024;~~ **10/17/2025**