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)

NON-PREFERRED **Trial and failure of 2 preferred biologics plus trial and failure of infliximab (unbranded 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) (unbranded Remicade)** 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 #: _____

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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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.

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

Member must meet FDA approved age and indication for coverage

❑ Diagnosis: Rheumatoid Arthritis

❑ Diagnosed for **Rheumatoid Arthritis**

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

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

- ❑ **Avsola®, Inflectra®, Remicade® or Renflexis®:**
  - ❑ Member has tried and failed **BOTH** 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 **OR** Starjemza™ (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 **OR** Starjemza™ (Requires trial and failure of a preferred TNF-alpha inhibitor)

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

❑ Diagnosis: Ankylosing Spondylitis

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

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

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- ❑ **Avsola®, Inflectra®, Remicade® or Renflexis®:**
  - ❑ Member has tried and failed **BOTH** 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 **OR** Starjemza™ (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 **OR** Starjemza™ (Requires trial and failure of a preferred TNF-alpha inhibitor)

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

❑ 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 **BOTH** of the preferred drugs below:

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

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

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

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

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❑ 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 **BOTH** of the preferred drugs below:

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

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

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

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

❑ Diagnosis: 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 **ONE (1)** 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**

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; 12/11/2025; 1/20/2026,~~ **2/26/2026**