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:** _____

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:** _____

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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, 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**
- ❑ Prescriber is a **Rheumatologist**
- ❑ Trial and failure of **ONE** of the **PREFERRED** drugs below:

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

- ❑ Trial and failure to Humira® or Enbrel® **AND** Infliximab therapy

❑ Diagnosis: Ankylosing Spondylitis

- ❑ Diagnosed for **active ankylosing spondylitis**
- ❑ Prescribed by or in consultation with a **Rheumatologist**
- ❑ Trial and failure, contraindication, or intolerance to **TWO** NSAIDs
- ❑ 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**

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- ❑ Prescribed by or in consultation with a Dermatologist
- ❑ Trial and failure of **ONE** of the **PREFERRED** drugs below:

❑ acitretin	❑ cyclosporine	❑ methotrexate

- ❑ Trial and failure to Humira® or Enbrel® **AND** Infliximab therapy

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

- ❑ Diagnosed for:
  - ❑ **Crohn's Disease** **OR** ❑ **Ocular Sarcoidosis**

- ❑ Prescribed by or in consultation with a **Gastroenterologist**
- ❑ Prescribed by or in consultation with an **Ophthalmologist**
- ❑ Inadequate response to high dose steroids (e.g.,40-60 mg prednisone)
- ❑ Trial and failure of **ONE** of the **PREFERRED** drugs below:

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

- ❑ Trial and failure to Humira® **AND** Infliximab therapy for Crohn's disease indication

❑ Diagnosis: Moderate-to-severe Ulcerative Colitis disease

- ❑ Diagnosed for moderate-to-severe **Ulcerative Colitis**
- ❑ Prescribed by or in consultation with a **Gastroenterologist**

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- ❑ Inadequate response to high dose steroids (e.g.40-60 mg prednisone)
- ❑ Trial and failure of **ONE** of the **PREFERRED** drugs below:

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

- ❑ Trial and failure to Humira® **AND** Infliximab therapy

Medication being provided by (check below that applies):

- ❑ **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.