univera HEALTHCARE

Remicade®(infliximab), **Renflexis**®(infliximab-abda)
Infliximab (unbranded)
(Self-Administration & Health Professional Administered)
Rx Benefit & Medical Benefit

Specialty Medication Review Program

Complete this form and fax to:

☐ **Medical Benefit (Office Admin)**
Fax #: 1-800-306-0188
Phone #: 1-800-499-1275

☐ **Accredo Health**
Fax: 1-888-773-7386
Phone: 1-866-413-4137

If healthcare prescriber administered, indicate how this medication will be obtained:

☐ **Walgreens Specialty Pharmacy**
Fax: 1-866-435-2173
Phone: 1-866-435-2171

☐ Option Care Home Infusion Sup
Phone:1-866-435-2171
Fax: 1-800-858-5408
Email: OC-SOCProgram@optioncare.com

Complete ALL the following Patient/Prescriber Information: (Please Print)

Patient Information	
Patient Name:	Patient Phone #: ( )
Patient ID #:	Patient Birthdate:
List Patient Allergy (If Any):	
Prescriber Information	
Prescriber Name:	Prescriber Specialty:
Prescriber Address:	
Prescriber Phone #:	Prescriber Fax #:
Prescriber NPI #:	Office Contact: Extension:

Medication Shipping Information	
1. If the patient is new to starting infliximab, the first dose may be administered in the patient's home. If being administered in the home, provide the patient address for delivery: _____	☐ Yes ☐ No
2. Location of Infusion if not being shipped to the patients home address: ☐ Prescriber office: _____ ☐ Outpatient facility: _____ ☐ Other: _____	
3. Servicing Prescriber NPI (if different from the ordering prescriber):	

Medication/Medical and Dispensing Information

Medication (HCPCS)	Dose	Frequency	Height	Weight (lbs. or kg)	Procedure Code
☐ Remicade (J1745)					
☐ Renflexis (Q5104)					
☐ Infliximab (unbranded) (J1745)					

Note, our **preferred products are Inflectra (Q5103) and Avsola (Q5121) which **do not** require a prior authorization.

1. Is this request for a: ☐ New Start **OR** ☐ Continuation of Therapy (recertification)? Start Date: _____	☐ Yes ☐ No
2. If this is a request for Remicade, Renflexis, or Infliximab (unbranded); has the patient had a previous trial of Inflectra and Avsola?	☐ Yes ☐ No
3. Diagnosis/ICD-10: _____	

Questions/Indications for Medical Necessity

**** See the Remicade & Infliximab Policy (Pharmacy-44) for full Prior Authorization criteria ****

Select one of the following diagnoses:

☐ Rheumatoid Arthritis	☐ Ankylosing	☐ Psoriatic Arthritis
☐ Ulcerative Colitis	☐ Chronic Severe Plaque Psoriasis	☐ Other: _____
☐ Crohn's Disease		

Rheumatoid Arthritis: Initial dosage 3mg/kg at weeks 0, 2, 6, & every 8 weeks thereafter. Max 5 infusions in 6 months

1. Has the diagnosis of Rheumatoid Arthritis been made by a rheumatologist?	☐ Yes ☐ No
2. Has patient had a trial of methotrexate 12.5mg – 15mg for at least 12 weeks?	☐ Yes ☐ No
3. List current dosage and duration of methotrexate_____	

Ankylosing Spondylitis: Dosage of 5mg/kg at weeks 0, 2, 6, and every 6 weeks thereafter

1. Is this patient being treated by a Rheumatologist?	☐ Yes ☐ No
2. Has patient had a trial of at least 2 different NSAIDs for at least 1 month? List all NSAID's used:	☐ Yes ☐ No

Drug Name	Dose & Frequency	Period of use	Outcomes
		Start: End:	
		Start: End:	
		Start: End:	

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Psoriatic Arthritis: Dosage of 5mg/kg at weeks 0, 2, 6, and every 8 weeks thereafter

1. Has this patient's diagnosis of psoriatic arthritis been established by? ☐ Dermatologist ☐ Rheumatologist	☐ Yes ☐ No
2. Has this patient had an adequate trial & failure of an NSAID or DMARD? (List)	☐ Yes ☐ No

Drug Name	Dose & Frequency	Period of use	Outcomes
		Start: End:	
		Start: End:	
		Start: End:	
		Start: End:	

Chronic Severe Plaque Psoriasis: Dosage of 5mg/kg at weeks 0, 2, 6, and every 8 weeks thereafter

1. Is this patient being treated by a Dermatologist?	☐ Yes ☐ No
2. Does the patient have active moderate to severe chronic plaque psoriasis?	% BSA:_____
3. Has the patient had treatment failure to first line drug therapy after a trial of at least 3 months? Indicate <u>which</u> drugs he/she has not responded to: ☐ acitretin, methotrexate, cyclosporine ☐ medium/high potency topical steroids ☐ UVB & Coal Tar or PUVA & topical steroids ☐ anthralin, calcipotriene, or tazarotene	☐ Yes ☐ No

Crohn's Disease: Dosage of 5mg/kg weeks 0, 2, 6, & every 8 weeks thereafter

1. Has the diagnosis of moderate to severe active Crohn's disease been made by a gastroenterologist?	☐ Yes ☐ No
2. Is the patient currently experiencing disease flare?	☐ Yes ☐ No
3. Has the patient had failure or intolerance to any of the following? (check all which apply along with time-period)	☐ Yes ☐ No

Drug Name	Dose & Frequency	Period of use	Outcomes
☐ Azathioprine		Start: End:	
☐ methotrexate		Start: End:	
☐ mercaptopurine		Start: End:	
☐ other (please list)		Start: End:	

Ulcerative Colitis: Dosage of 5mg/kg at 0, 2, 6, weeks and every 8 weeks thereafter

1. Has the diagnosis of Ulcerative Colitis been made by a Gastroenterologist?	☐ Yes ☐ No
2. Has the patient had failure or intolerance to at least **ONE** of the agents listed below?	

Drug Name	Dose & Frequency	Period of use	Outcomes
☐ Thiopurines (azathioprine,mercaptopurine)		Start: End:	
☐ 5-Aminosalicylates (sulfasalazine, mesalamine, olsalazine)		Start: End:	
☐ IV or oral steroids		Start: End:	
☐ Cyclosporine		Start: End:	

Provide Other Comments/Clinical Justification:

****ATTACH CLINICAL NOTES RELATED TO THIS REQUEST. IF DOCUMENTATION IS NOT PROVIDED, IT MAY DELAY THE REQUEST****

***Prescriber Signature:**_____ **Date:**_____

I certify the above information is true and accurate to the best of my knowledge.