1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Inflectra®, Remicade® & Renflexis® Prior Authorization Request Form (Page 1 of 2)

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Active ankylosing spondylitis
- ❑ Active psoriatic arthritis
- ❑ Chronic severe plaque psoriasis
- ❑ Crohn's disease
- ❑ Moderately to severely active rheumatoid arthritis
- ❑ Moderately to severely active ulcerative colitis
- ❑ Sarcoidosis
- ❑ Other diagnosis:_____ICD-10 Code(s): _____

Clinical Information:

Select if Inflectra is prescribed by or in consultation with one of the following specialists, if applicable for the patient's diagnosis:

❑ Dermatologist ❑ Gastroenterologist ❑ Rheumatologist ❑ Pulmonologist

Select if infliximab be used in combination with the following:

- ❑ Biologic DMARD [e.g., Enbrel (etanercept), Rituxan (rituximab), Orencia (abatacept), Kineret (anakinra), Cimzia (certolizumab)]
- ❑ Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- ❑ Not in combination with a biologic DMARD or janus kinase inhibitor

For Inflectra and Renflexis requests only:

Does the patient have history of failure, contraindication, or intolerance to Remicade? ❑ **Yes** ❑ **No**

For active ankylosing spondylitis, also answer the following:

Does the patient have history of failure, contraindication, or intolerance to two non-steroidal anti-inflammatory drugs (NSAIDs)? ❑ **Yes** ❑ **No**

For Crohn's disease, also answer the following:

Select if the patient has one of the following diagnoses:

- ❑ Fistulizing Crohn's disease
- ❑ Moderately to severely active Crohn's disease

Select if the patient has history of failure, contraindication, or intolerance to the following:

- ❑ 6-mercaptopurine (Purinethol)
- ❑ Azathioprine (Imuran)
- ❑ Corticosteroids (e.g., prednisone, methylprednisolone)
- ❑ Methotrexate (Rheumatrex, Trexall)

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For moderately to severely active rheumatoid arthritis, also answer the following:

Is the patient receiving concurrent therapy with methotrexate (Rheumatrex, Trexall)? ❑ **Yes** ❑ **No**

Does the patient have history of failure, contraindication, or intolerance to methotrexate (Rheumatrex, Trexall)? ❑ **Yes** ❑ **No**

For moderately to severely active ulcerative colitis, also answer the following:

Select if the patient has history of failure, contraindication, or intolerance to the following:

- ❑ 6-mercaptopurine (Purinethol)
- ❑ Aminosalicylate [e.g., mesalamine (Asacol, Pentasa, Rowasa), olsalazine (Dipentum), sulfasalazine (Azulfidine, Sulfazine)]
- ❑ Azathioprine (Imuran)
- ❑ Corticosteroids (e.g., prednisone, methylprednisolone)

For sarcoidosis, also answer the following:

Does the patient have history of failure, contraindication, or intolerance to corticosteroids (e.g., prednisone)? ❑ **Yes** ❑ **No**

Does the patient have history of failure, contraindication, or intolerance to one immunosuppressant [e.g., methotrexate (Rheumatrex, Trexall), Cytoxan (cyclophosphamide), or Imuran (azathioprine)]? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following questions:

Is there documentation the patient has had a positive clinical response to infliximab therapy? ❑ **Yes** ❑ **No**

Select if infliximab be used in combination with the following:

- ❑ Biologic DMARD [e.g., Enbrel (etanercept), Rituxan (rituximab), Orencia (abatacept), Kineret (anakinra), Cimzia (certolizumab)]
- ❑ Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- ❑ Not in combination with a biologic DMARD or janus kinase inhibitor

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	