PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Inflectra & Renflexis (infliximab biosimilars)

Phone: 800-728-7947 **Fax back to: 866-880-4532**

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. What diagnosis is this drug being prescribed for (select ALL that apply)?

- ☐ Ankylosing Spondylitis
- ☐ Crohn's Disease
- ☐ Plaque Psoriasis
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Ulcerative Colitis
- ☐ Acute Graft-Versus-Host Disease
- ☐ Adult Onset Still's Disease
- ☐ Arthropathy in Inflammatory Disease
- ☐ Behcet's Syndrome
- ☐ Early Synovitis in Rheumatoid Arthritis
- ☐ Hidradenitis Suppurativa
- ☐ Juvenile Idiopathic Arthritis
- ☐ Kawasaki Disease
- ☐ Pyoderma Gangrenosum
- ☐ Reiter's Disease

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- ☐ SAPHO Syndrome
- ☐ Sarcoidosis
- ☐ Takayasu's Disease
- ☐ Uveitis
- ☐ Uveitis in Behcet's Syndrome
- ☐ Wegener's Granulomatosis
- ☐ Other

Q2. Select the regimen being requested.

- ☐ 5 mg/kg every 6 weeks
- ☐ 3 mg/kg every 8 weeks
- ☐ 5 mg/kg every 8 weeks
- ☐ 10 mg/kg every 8 weeks
- ☐ Other (please specify)

Q3. Provide ICD code(s) for diagnosis.

Q4. What is the patient's weight?

Q5. Is this a new start for this patient? If not, please specify start date.

☐ Yes ☐ No

Q6. Does the patient have failure to brand Remicade? Failure is defined as a history of a trial of at least 14 weeks of Remicade resulting in minimal clinical response to therapy and residual disease activity.

☐ Yes ☐ No

Q7. Does the physician attest that, in their clinical opinion, the clinical response would be expected to be superior with an infliximab biosimilar product, than experienced with Remicade?

☐ Yes ☐ No

Q8. Does the patient have a history of intolerance or adverse event to brand Remicade?

☐ Yes ☐ No

Q9. Does the physician attest that, in their clinical opinion, the same intolerance or adverse event would not be

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expected to occur with an infliximab biosimilar product?

☐ Yes ☐ No

Q10. Does the patient have any of the following? Please select all that apply.

☐ Loss of a favorable response after established maintenance therapy with Remicade or other infliximab biosimilar product

☐ Developed neutralizing antibodies to any infliximab biosimilar product that has led to an attenuation of efficacy of therapy

☐ None of the above

Q11. How will drug be billed?

☐ Pharmacy claim (drug to be billed as a PHARMACY benefit claim and dispensed by pharmacy directly to member)

☐ Pharmacy claim (drug to be billed as a PHARMACY benefit claim, but shipped direct to provider to be administered to this specific member)

☐ MEDICAL claim (drug to be billed by PROVIDER as a MEDICAL benefit claim as an expense to the provider, and provider to supply drug to member)

Q12. If billing as a MEDICAL claim, what provider will be linked to the claim (i.e. who is the billing entity seeking reimbursement)? Provide Name and NPI

☐ Individual prescriber

☐ Provider or specialty group

☐ Facility

Q13. Additional Comments

Prescriber Signature

Date

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□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.