PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Inflectra (infliximab-dyyb)

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
- ☐ 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

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☐ 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 and Renflexis? Failure is defined as a history of a trial of at least 14 weeks of preferred agents 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 Inflectra, than experienced with Remicade and Renflexis?

☐ Yes ☐ No

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

☐ Yes ☐ No

Q9. Does the physician attest that, in their clinical opinion, the same intolerance or adverse event would not be expected to occur with Inflectra?

☐ Yes ☐ No

Q10. Please select all that apply to the patient

☐ Loss of a favorable response after established maintenance therapy with Remicade or Renflexis
☐ Developed neutralizing antibodies to any infliximab biosimilar product that has led to an attenuation of efficacy of therapy
☐ Previously stable on Remicade or Renflexis and switched to Inflectra
☐ None of the above

Q11. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement?

☐ Pharmacy

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☐ Individual prescriber
☐ Provider or specialty group
☐ Facility
☐ Other (please specify)

Q12. Provide name and NPI of the billing entity

Q13. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)?

☐ Medical ☐ Pharmacy

Q14. Additional Comments

Prescriber Signature

Date

□ 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.

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