

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Renflexis (infliximab-abda)

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.

Deticut News	Prescriber Name:		
Patient 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:	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 (s	elect ALL that apply)?		
☐ Ankylosing Spondylitis	☐ Juvenile Idiop	eathic Arthritis	
☐ Crohn's Disease	☐ Kawasaki Dis	ease	
☐ Plaque Psoriasis	Pyoderma Ga	☐ Pyoderma Gangrenosum	
☐ Psoriatic Arthritis	Reiter's Disea	☐ Reiter's Disease	
☐ Rheumatoid Arthritis	☐ SAPHO Synd	rome	
Ulcerative Colitis	☐ Sarcoidosis		
Acute Graft-Versus-Host Disease	☐ Takayasu's D	isease	
Adult Onset Still's Disease	☐ Uveitis	☐ Uveitis	
☐ Arthropathy in Inflammatory Disease	Uveitis in Beh	cet's Syndrome	
☐ Behcet's Syndrome	☐ Wegener's Gr	ranulomatosis	
☐ Early Synovitis in Rheumatoid Arthritis	☐ Other		
☐ Hidradenitis Suppurativa			
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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	Prescriber Name:	
Patient Name:	Supervising Physician:	
☐ 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?		
☐ Yes	☐ No - please specify start date	
Q6. Who is the ENTITY that will be submitting the CLAIM f Pharmacy Individual prescriber Provider or specialty group Facility Other (please specify)	for the DRUG and seeking reimbursement?	
Q7. Provide name and NPI of the billing entity		
Q8. 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 - NO PRIOR AUTHORIZATION REQUIRED	☐ Pharmacy	
Q9. Additional Comments		



PRIOR AUTHORIZATION REQUEST FORM EOC ID: Denfloying (infliction of a chala)

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	Prescriber Name:	
Patient Name:	Supervising Physician:	
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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