pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

REMICADE/INFLECTRA/RENFLEXIS (infliximab) [non-preferred] PRIOR AUTHORIZATION FORM

Cytokine and CAM Antagonists and **Quantity Limits/Daily Dose Limits** prior authorization guidelines: http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Product requested: ☐Inflectra 100 mg vial ☐Renflexis 100 mg vial* ☐Remicade 100 mg vial ☐_____	Dose & frequency:	# of vials:	Refills:
Diagnosis (*submit documentation*):	Dx code (*required*):	Weight: _____ lbs / kg	

Specialty Pharmacy Drug Program: Which specialty pharmacy will be used*? ☐Diplomat Specialty ☐Walgreen's Specialty
***Note**: Renflexis is currently not available from Diplomat Specialty Pharmacy.

INITIAL requests – complete questions applicable to beneficiary's diagnosis

1. ***All diagnoses***: Check all that apply to the beneficiary and *submit documentation for each*.
   ☐vaccinated for hepatitis B ☐screened for hepatitis B (surface antigen & core antibody) ☐has been using the requested infliximab product in the past 90 days
   ☐screened for tuberculosis ☐up-to-date with all age-appropriate immunizations

2. ***All diagnoses***: Is the beneficiary currently receiving therapy with an infliximab agent?	☐Yes - *Submit documentation.*	☐No
3. ***All diagnoses***: Does the beneficiary have moderate or severe heart failure?	☐Yes - *Submit documentation.*	☐No

4. ***Ankylosing spondylitis or psoriatic arthritis***: Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the following? ☐4-week trial each of 2 different NSAIDs ☐Cosentyx ☐Humira ☐Xeljanz *(PsA)* ☐8-week trial of methotrexate or other DMARD *(does not apply to axial disease)*	☐Yes ☐No *Submit documentation of all medications tried and outcomes.*
5. ***Crohn's disease***: Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the following? ☐aminosalicylates ☐corticosteroids ☐immunomodulators ☐Humira	☐Yes ☐No *Submit documentation of all medications tried and outcomes.*
6. ***Ulcerative colitis***: Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the following? ☐aminosalicylates ☐corticosteroids ☐immunomodulators ☐Humira ☐Xeljanz	☐Yes ☐No *Submit documentation of all medications tried and outcomes.*
7. ***Rheumatoid arthritis***: Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the following medications? *Check all that apply.* ☐3 months of methotrexate or other DMARD ☐Humira ☐Xeljanz	☐Yes ☐No *Submit documentation of all medications tried and outcomes.*
8. ***Plaque psoriasis***: Does at least one of the following apply to the beneficiary? ☐at least 5% of body surface area (BSA) is affected ☐critical areas of the body are involved (face, palms, soles, and/or genitals)	☐Yes ☐No *Submit documentation.*
9. ***Plaque psoriasis***: Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the following treatments and medications? *Check all that apply.* ☐3 months of PUVA ☐3 months of UVB light ☐methotrexate ☐ Cosentyx ☐acitretin ☐cyclosporine ☐Humira	☐Yes ☐No *Submit documentation treatments tried and outcomes.*

10. ***Uveitis***: Check all of the following that apply to the beneficiary and *submit documentation for each*.
    ☐has a diagnosis of uveitis associated with juvenile idiopathic arthritis or Behçet's disease
    ☐has steroid-dependent uveitis (i.e., requires ≥ prednisone 7.5 mg daily [or equivalent]) with plan to taper or discontinue systemic steroids
    ☐has a documented history of trial & failure, contraindication, or intolerance of systemic immunosuppressives or corticosteroids (systemic, topical, intraocular, or periocular) **and** Humira
11. ***All other diagnoses***: Submit documentation supporting the use of infliximab for the beneficiary's diagnosis & other treatments tried.

RENEWAL requests

1. *Submit documentation of how the requested medication has helped the beneficiary's condition and level of functioning.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**:

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