BlueCross BlueShield
Federal Employee Program

INFLIXIMAB
MEDICAL BENEFIT ONLY
PRESCRIBER
PRIOR AUTHORIZATION FORM

Fax completed form to:
1-844-652-8285

Patient Information (required)			Provider Information (required)		
Date:			Provider Name and Office Contact:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ☐ Male ☐ Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
HCPCS code:			ICD-10:		
Patient ID: **R**			Physician Signature:		
Patient's weight:			Dose and Frequency of Requested Medication:		

PHYSICIAN COMPLETES

Infliximab

NOTE: Form must be completed in its **entirety** for processing, **please check ALL boxes that apply.**

Which product is being requested: ☐ Remicade ☐ Avsola ☐ Inflectra ☐ Renflexis ☐ Ixifi ☐ Infliximab

☐ This is **INITIATION** of therapy (if this is a continuation of therapy proceed to **PAGE 4**)

Patient's diagnosis is:

☐ Crohn's disease (CD); moderate to severely active

- ☐ Patient is 6 years of age or older.
- ☐ Patient had an inadequate response, intolerance, or contraindication to *conventional therapy for Crohn's disease.
  Examples of conventional therapies: methotrexate, azathioprine, mercaptopurine or prednisone
- ☐ FOR PEDIATRIC PATIENTS ONLY: Patient is up to date with all vaccinations.

☐ Ulcerative Colitis (UC); moderate to severely active

- ☐ Patient is 6 years of age or older.
- ☐ Patient had an inadequate response, intolerance, or contraindication to *conventional therapy for UC disease.
  Examples of conventional therapies: oral mesalamine, balsalazide, prednisone, azathioprine, or sulfasalazine
- ☐ FOR PEDIATRIC PATIENTS ONLY: Patient is up to date with all vaccinations.

☐ Juvenile Idiopathic Arthritis (JIA)

- ☐ Patient is 12 years of age or older.
- ☐ Patient had an inadequate response to at least a three-month trial of, or an intolerance or contraindication to a self-injectable *TNF inhibitor for JIA. ***Examples of TNF inhibitors include but are not limited to: Humira and Enbrel***

☐ Rheumatoid Arthritis (RA); moderate to severely active

- ☐ Patient is 18 years of age or older.
- ☐ Patient had an inadequate response to at least a three-month trial of methotrexate despite adequate dosing (i.e., titrated to 20 mg/week) or an intolerance or contraindication to methotrexate.
- ☐ Patient will also be on either methotrexate or leflunomide unless not tolerated or contraindicated.

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES AND PA REQUIREMENTS

PAGE 2 - PHYSICIAN COMPLETES

Patient Name:_____ **DOB:**_____ **Patient ID:** _____

☐ Ankylosing Spondylitis (AS) / axial spondyloarthritis; active

- ☐ Patient is 18 years of age or older.
- ☐ Patient had an inadequate response to at least **TWO** non-steroidal anti-inflammatory drugs (NSAIDs) over a four-week period in total at the maximum recommended or tolerated anti-inflammatory doses.

☐ Plaque Psoriasis (PsO); severe

- ☐ Patient is 18 years of age or older.
- ☐ Patient has an affected body surface area (BSA) of at least 5% OR crucial body areas such as hands, feet, face, neck, scalp, genitals/groin, and intertriginous areas are affected.
- ☐ Patient had an inadequate response to at least ONE of the following:
  - ☐ *Conventional systemic therapy. ****Examples of conventional therapies: methotrexate, cyclosporine or acitretin***
  - ☐ Phototherapy
- ☐ Patient did not tolerate or has a contraindication to BOTH therapies:
  - ☐ *Conventional systemic therapy. ****Examples of conventional therapies: methotrexate, cyclosporine or acitretin***
  - ☐ Phototherapy

☐ Psoriatic Arthritis (PsA); active

- ☐ Patient is 18 years of age or older.
- ☐ Patient had an inadequate response to a three-month trial of, or an intolerance or contraindication to at least **ONE** *conventional disease-modifying antirheumatic drug (DMARD). ****Examples of conventional DMARDs: methotrexate, leflunomide, or azathioprine***

☐ Behcet's Syndrome

- ☐ Patient is 18 years of age or older.

☐ Granulomatosis with Polyangiitis (Wegener's Granulomatosis)

- ☐ Patient is 18 years of age or older.

☐ Hidradenitis Suppurativa

- ☐ Patient is 18 years of age or older.

☐ Pyoderma Gangrenosum

- ☐ Patient is 18 years of age or older.

☐ Sarcoidosis

- ☐ Patient is 18 years of age or older.

☐ Takayasu's Arteritis

- ☐ Patient is 18 years of age or older.

☐ Uveitis

- ☐ Patient is 18 years of age or older.
- ☐ Patient had an inadequate response, intolerance, or contraindication to a trial of *immunosuppressive therapy for uveitis. ****Examples of immunosuppressive therapies: azathioprine, cyclosporine, methotrexate, or mycophenolate***

☐ Other diagnosis (please provide clinical documentation supporting medical necessity)

PLEASE PROCEED TO PAGE 3 FOR ADDITIONAL PRIOR AUTHORIZATION REQUIREMENTS

PAGE 3 - PHYSICIAN COMPLETES

Patient Name:_____ **DOB:**_____ **Patient ID:** _____

****Please continue checking all boxes that apply (Failure to check all appropriate boxes may result in delay of coverage):****

☐ **FOR REQUESTS OF NON-PREFERRED INFLIXIMAB PRODUCTS ONLY (i.e,. Avsola, Ixifi, Renflexis):** Treatment with at least **ONE** preferred product (i.e., Inflectra, Infliximab, Remicade) was ineffective or not tolerated or is contraindicated.

☐ Patient had a tuberculosis (TB) test prior to initiating therapy to confirm no active TB or if latent TB infection is present, treatment for the infection will start prior to the use of an infliximab product.

☐ Patient has **NO** active infections.

☐ Infliximab product will NOT be used in combination with another biologic *disease-modifying antirheumatic drug (DMARD) or targeted synthetic DMARD.

DMARD includes: Actemra, Avsola, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Renflexis, Rinvoq, Rituxan, Siliq, Simponi/Simponi Aria, Skyrizi, Stelara, Taltz, Tremfya, and Xeljanz

☐ Patient is not at risk for hepatitis B (HBV) infection OR is at risk for HBV infection, but it has been ruled out for this patient OR therapy has been started for treatment of the HBV infection.

☐ Patient will **NOT** be given live vaccines while on an infliximab product.

☐ **Physician agrees to the following dosing regimen corresponding to the patient's diagnosis (Please select appropriate boxes):**

- ☐ FOR Crohn's Disease (CD) and Ulcerative Colitis (UC), up to 10 mg/kg /cycle for 4 cycles for 4 months.
- ☐ FOR Rheumatoid Arthritis & Juvenile Idiopathic Arthritis, 3 mg/kg/cycle for 5 cycles for 6 months.
- ☐ FOR diagnoses OTHER than Rheumatoid Arthritis, Juvenile Idiopathic Arthritis, Crohn's Disease, and Ulcerative Colitis, 5mg/kg/cycle for 4 cycles for 4 months. These diagnoses include:
  - Ankylosing Spondylitis (AS) / axial spondyloarthritis
  - Plaque Psoriasis (PsO)
  - Psoriatic Arthritis (PsA)
  - Behcet's Syndrome
  - Granulomatosis w/Polyangiitis (Wegener's granulomatosis)
  - Hidradenitis Suppurativa
  - Pyoderma Gangrenosum
  - Sarcoidosis
  - Takayasu's Arteritis
  - Uveitis

☐ Physician wishes to give dosing at a higher dose or frequency than stated above. (please submit clinical documentation to support medical necessity)

PLEASE NOTE: Infliximab products may be considered investigational in patients with all other indications.

PLEASE PROCEED TO PAGE 4 FOR CONTINUATION OF THERAPY REQUESTS

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Patient Information (required)			Provider Information (required)		
Date:			Provider Name and Office Contact:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ☐ Male ☐ Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
HCPCS code:			ICD-10:		
Patient ID: R			Physician Signature:		
Patient's weight:			Dose and Frequency of Requested Medication:		

PHYSICIAN COMPLETES

CONTINUATION OF THERAPY (PA RENEWAL)
Infliximab

NOTE: Form must be completed in its **entirety** for processing, **please check ALL boxes that apply.**

Which product is being requested: ☐ Remicade ☐ Avsola ☐ Inflectra ☐ Renflexis ☐ Ixifi ☐ Infliximab

☐ This is a PA renewal for **CONTINUATION** of therapy, the patient been on infliximab or a biosimilar continuously for the last **4 months** for **rheumatoid arthritis OR** for the last **3 months** for **ALL other diagnoses**, excluding samples.

☐ Patient is 6 years of age or older AND has **ONE** of the following diagnoses:

- ☐ Crohn's Disease (CD)
- ☐ Ulcerative Colitis (UC)

☐ Patient is 12 years of age or older AND has the following diagnosis:

- ☐ Juvenile Idiopathic Arthritis (JIA)

☐ Patient is 18 years of age or older AND has **ONE** of the following diagnoses:

- ☐ Rheumatoid Arthritis (RA)
- ☐ Ankylosing Spondylitis (AS) / axial spondyloarthritis
- ☐ Psoriatic Arthritis (PsA)
- ☐ Plaque Psoriasis (PsO)
- ☐ Behcet's Syndrome
- ☐ Granulomatosis w/Polyangiitis (Wegener's Granulomatosis)
- ☐ Hidradenitis Suppurativa
- ☐ Pyoderma Gangrenosum
- ☐ Sarcoidosis
- ☐ Takayasu's Arteritis
- ☐ Uveitis

☐ Other diagnosis (please submit clinical documentation to support ongoing medical necessity)

PLEASE PROCEED TO PAGE 5 FOR ADDITIONAL PA REQUIREMENTS

PAGE 5 - PHYSICIAN COMPLETES

Patient Name:_____ **DOB:**_____ **Patient ID:** _____

****Please continue checking all boxes that apply (Failure to check all appropriate boxes may result in delay of coverage):****

- ☐ **Patient's condition has improved or stabilized.**
- ☐ Patient does NOT have any active infections including tuberculosis (TB) and hepatitis B (HBV).
- ☐ Infliximab product will NOT be used in combination with another biologic *disease-modifying antirheumatic drug (DMARD) or targeted synthetic DMARD.

  DMARD includes: Actemra, Avsola, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Renflexis, Rinvoq, Rituxan, Siliq, Simponi/Simponi Aria, Skyrizi, Stelara, Taltz, Tremfya, and Xeljanz

- ☐ Patient will NOT be given live vaccines while on an infliximab product.
- ☐ **Physician agrees to the following dosing regimen corresponding to the patient's diagnosis (Please select appropriate boxes):**
  - ☐ FOR Ankylosing Spondylitis, 5 mg/kg/cycle for 9 cycles for 12 months (every 6 weeks).
  - ☐ FOR Crohn's Disease & Ulcerative Colitis, up to a MAX of 10 mg/kg/cycle for 7 cycles for 12 months (every 8 weeks).
  - ☐ FOR Rheumatoid Arthritis & Juvenile Idiopathic Arthritis, 3 mg/kg/cycle for 7 cycles for 12 months (every 8 weeks).
    - ☐ Patient did not respond to dosing regimen of 3 mg/kg/cycle every 8 weeks and requires a higher dosage or more frequent dosing per cycle.
    - ☐ Physician agrees to give a MAX dose of 10 mg/kg/cycle OR to give no more frequently than every 4-week dosing.
  - ☐ FOR diagnoses OTHER than Ankylosing Spondylitis, Crohn's Disease, Ulcerative Colitis, Rheumatoid Arthritis and Juvenile Idiopathic Arthritis, 5 mg/kg/cycle for 7 cycles for 12 months (every 8 weeks). These diagnoses include:
    - Plaque Psoriasis (PsO)
    - Psoriatic Arthritis (PsA)
    - Behcet's Syndrome
    - Granulomatosis w/Polyangiitis (Wegener's granulomatosis)
    - Hidradenitis Suppurativa
    - Pyoderma Gangrenosum
    - Sarcoidosis
    - Takayasu's Arteritis
    - Uveitis
- ☐ Physician wishes to give dosing at a higher dose or frequency than stated above. (<u>please submit clinical documentation to support medical necessity</u>)

PLEASE NOTE: Infliximab products may be considered investigational in patients with all other indications.