reliance|rx℠
15 Earhart Drive, Suite 101, Amherst, NY 14221

INFLIXIMAB AUTHORIZATION AND REAUTHORIZATION REQUEST

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Member Name:		Today's Date:	Date Needed:
Date of birth:	Sex: Weight:	Prescriber:	Specialty:
Home Phone Number: ( )		Phone Number: ( )	Fax Number: ( )
Home Address:	City: State: Zip:	Address	City: State: Zip:
Payor: ☐ Independent Health ☐ Anne Arundel Health System ☐ Pharmacy Benefit Dimensions ☐ Commercial ☐ Medicaid ☐ Medicare ☐ Self-Funded Insurance ID: Group Number:		Allergies: Additional Notes:	

DRUG SELECTION

☐ **REMICADE** ☐ **RENFLEXIS** ☐ **INFLECTRA** ☐ **AVSOLA**

Dose: _____

Frequency: _____

Expected duration of therapy: _____

Primary Diagnosis: _____

ICD 10 Code: _____

Please list all medications that patient has tried for the above diagnosis: _____

_____

_____

General Authorization Criteria:

☐ Place of administration has appropriate staff, equipment and medications to treat infusion-related reactions including epinephrine, diphenhydramine, corticosteroids, and oxygen

Does patient have congestive heart failure? ☐ Yes ☐ No

Patient's weight: _____ Date: _____

Has the patient has been screened for latent TB infection? (i.e. tuberculin skin test or QuantiFERON®-TB Gold). ☐ Yes ☐ No

Please submit tuberculosis test result.

<u>If this test is positive, then:</u>

- Patient must be evaluated for latent tuberculosis before initiating infliximab therapy (latent tuberculosis should be treated before starting infliximab.); and

ADDITIONAL CRITERIA

<u>For treatment of Rheumatoid Arthritis:</u>
In addition to meeting the general criteria, the following conditions must be met.

☐ Diagnosis of rheumatoid arthritis by a rheumatologist

☐ Authorization request must come from a rheumatologist (or under the documented recommendation of a rheumatologist)

☐ Patient has failed to respond to a three (3) month trial of one (1) medication deemed a conventional agent for rheumatoid arthritis, such as methotrexate, sulfasalazine, leflunomide, and hydroxychloroquine.

Please list: _____

<u>For acute treatment and management of Crohns Disease:</u>
In addition to meeting the general criteria, the following conditions must be met.

☐ Diagnosis of Crohn's disease or fistulizing Crohn's disease by a gastroenterologist

☐ Prior Authorization Request must come from a gastroenterologist (or under the documented recommendation of a gastroenterologist)

☐ Patient has failed to respond to a three (3) month trial of one (1) medication deemed a conventional agent for Crohn's disease, such as methotrexate, azathioprine, aminosalicylates, 6-mercaptopurine, corticosteroids (including budesonide EC capsule), metronidazole, cyclosporine, and ciprofloxacin.

Please list: _____

<u>For Pediatric Patients with Moderately to Severely Active Crohns Disease:</u>
In addition to meeting the general criteria, the following conditions must be met:

☐ Prior Authorization Request must come from a gastroenterologist (or

- Submission of yearly screening for latent TB, such as annual TB skin testing results, is required for patients who live, travel, or work in situations where TB exposure is likely while on treatment or for those who have previously tested positive.

☐ Patient has failed to respond to a three (3) month trial of one (1) medication deemed a conventional agent for Crohn's disease , such as methotrexate, azathioprine, aminosalicylates, 6-mercaptopurine, corticosteroids (including budesonide EC capsule), metronidazole, cyclosporine, and ciprofloxacin.

Please list: _____

For Ankylosing Spondylitis:

In addition to meeting the general criteria, the following conditions must be met:

☐ The Authorization Request must come from a rheumatologist (or under the documented recommendation of a rheumatologist)

☐ Patient has failed to respond to a three (3) month trial of one (1) medication deemed a conventional agent for Ankylosing Spondylitis, such as NSAIDS, sulfasalazine, and Intraarticular corticosteroid therapy.

Please list: _____

For Psoriatic Arthritis:

In addition to meeting the general criteria, the following conditions must be met:

☐ The Authorization Request must come from a rheumatologist or dermatologist (or under the documented recommendation of a rheumatologist or dermatologist)

☐ Patient has failed to respond to a three (3) month trial of one (1) medication deemed a conventional agent for psoriatic arthritis, such as methotrexate, sulfasalazine, leflunomide, hydroxychloroquine, and NSAIDS

Please list: _____

☐ Patient must have clinical features of psoriatic arthritis such as: involvement of the DIP joints, an asymmetric distribution of joint disease, spondylarthrosis, sausage digits, new bone formation on radiographs, cutaneous findings, and the characteristic nail manifestations of psoriatic arthritis (nail pitting, onycholysis and/or other lesions, which include leukonychia, red spots in the lunula, and nail plate crumbling).

Please specify: _____

_____

under the documented recommendation of a gastroenterologist)

☐ Patient is six years of age or older with a diagnosis of moderately to severely active Crohn's disease

For Plaque Psoriasis:

In addition to meeting the general criteria, the following conditions must be met:

☐ The Authorization Request must come from a dermatologist (or under the documented recommendation of a dermatologist)

☐ Duration of disease is greater than one year

☐ Chronic stable severe plaque psoriasis must cover at least 10% of total BSA; or

☐ Hands and/or feet of the patient are affected and severely interfere with the activities of daily living

☐ Patient has failed to respond to a three (3) month trial of one (1) medication deemed a conventional agent for psoriasis, such as methotrexate, tazarotene, topical corticosteroids, cyclosporine, anthralin, tacrolimus, calcitriol, PUVA (phototherapy), and acitretin.

Please list: _____

For Moderate to Severely Active Ulcerative Colitis:

In addition to meeting the general criteria, the following conditions must be met:

☐ Diagnosis of moderately to severely active ulcerative colitis by a gastroenterologist

☐ Prior Authorization Request must come from a gastroenterologist (or under the documented recommendation of a gastroenterologist); and

☐ Patient is 6 years of age or older

☐ Patient has failed to respond to a three (3) month trial of one (1) medication deemed a conventional agent for Ulcerative colitis, such as methotrexate, azathioprine, aminosalicylates, 6-mercaptopurine, corticosteroids (including budesonide EC capsule), and cyclosporine.

Please list: _____

For Re-Authorization:

Coverage can be renewed based upon the following criteria:

☐ Patient continues to meet initiation criteria identified.

☐ Absence of unacceptable toxicity from the drug.

☐ Ongoing monitoring for TB as noted under criteria for authorization

☐ Clinical response or remission of disease is maintained with continued use