Neighborhood Health Plan OF RHODE ISLAND™

Remicade, Inflectra, Renflexis Authorization form

Tel. 401-427-8200; Fax 844-639-7906

Remicade(infliximab) J1745, Inflectra (infliximab-dyyb) Q5103, Renflexis (infliximab-abda) Q5104 Prior Authorization form (Drugs Administered in Office), fax requests to 844-639-7906

Please complete the form by providing all of the following information. Failure to fill out this form in its entirety may delay the review process. To review the Clinical Medical Policies, please visit our website at https://www.nhpri.org/Providers/ClinicalMedicalPolicies.aspx

MEMBER INFORMATION		
Member's Name:	Member's ID #:	Member's DOB:
Member Phone Number:	Member Address:	Gender: □ Male □Female □Unknown Primary Language: □ English □Spanish □ Other:
REQUESTING PROVIDER INFORMATION		
Provider's Name:	Provider's Phone #:	Provider's Fax #:
Date of Request:	Provider's NPI #:	Provider's Contact Name and Phone:

SERVICING PROVIDER INFORMATION (Must be filled out appropriately to ensure claim adjudication)

HOW WILL MEDICATION BE OBTAINED:

❑ Drop Ship from Specialty Pharmacy: _____and NPI_____

❑ If Buy & Bill: Specify Provider/ Facility: _____ and NPI _____

Servicing Provider Fax#: _____

CLINICAL INFORMATION		
Requested J-Code:	Requested CPT code(s):	□ Initial Request □ Continuation of therapy Request
Drug Name& strength:		Date(s) of Service Requested:
Directions:		# of units:
ICD 10 Codes:		

Clinical Assessment (provide all required information and clinical documents)	YES	NO
Has the patient submitted documentation that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test) as indicated in package insert?	☐	☐
Crohn's Disease:		☐
Is the member ≥6 year old & have a documented clinical diagnosis of moderate to severely active Crohn's disease?	☐	☐
Does the patient have a documented (consistent with pharmacy claims data, OR for new members to the health plan consistent with medical chart history) adequate trial (including dates and doses) at therapeutic doses or has a documented clinically significant medical reason for not receiving conventional oral therapy (e.g. azathioprine, corticosteroids, 6-mercaptopurine) to manage their medical condition?	☐	☐

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The medication requested has an FDA approved indication for use in patients with moderate to severe active Crohn's disease and is being recommended and prescribed by a gastroenterologist at an FDA-approved dosage?	☐	☐
Continuation of therapy for Crohn's disease: Is the patient tolerating treatment?	☐	☐
Is the medication being recommended and prescribed by a gastroenterologist for an FDA-approved indication at an FDA-approved dosage?	☐	☐
Patient has experienced disease improvement in signs and symptoms compared to baseline such as endoscopic activity, number of liquid stools, presence and severity of abdominal pain, presence of abdominal mass, body weight compared to IBW, hematocrit, presence of extra-intestinal complications, use of anti-diarrheal drugs, and/or an improvement on a disease activity scoring tool?	☐	☐
Ulcerative Colitis:	☐	
Is the patient is ≥6 years old and has moderate to severe active ulcerative colitis?	☐	☐
The patient has a documented (consistent with pharmacy claims data, OR for new members to the health plan consistent with medical chart history) treatment failure after receiving an adequate trial of: Sulfasalazine (3 to 6 g/day for 3 months), or mesalamine (1.2 to 2.4 g/day for 3 months), or azathioprine (2 to 2.5 mg/kg/day), or 6-mercaptopurine (1.5 to 2 mg/kg/day), or oral corticosteroids or has a documented medical reason (GI intolerance, hypersensitivity, etc.) for not taking any of these medications to treat their medical condition?	☐	☐
Does the medication requested has a FDA approved indication for use in patients with moderate to severe active ulcerative colitis and is being prescribed at an FDA-approved dosage and is recommended or prescribed by a gastroenterologist?	☐	☐
Continuation of therapy for Ulcerative Colitis	☐	☐
Is the Patient tolerating treatment?	☐	☐
Is the medication being recommended and prescribed by a gastroenterologist for an FDA-approved indication at an FDA-approved dosage?	☐	☐
Documentation submitted indicates that the member has obtained clinical benefit from the medication?	☐	☐
Plaque Psoriasis:	☐	☐
Is the patient 18 years of age and older?	☐	☐
Does the patient have a diagnosis of moderate to severe plaque psoriasis and is being recommended or prescribed by a dermatologist at an FDA-approved dosage?	☐	☐

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Documentation that the patient has had (consistent with pharmacy claims data, OR for new members to the health plan consistent with medical chart history) adequate trials (including dates and doses) of at least 3 of the treatment bullet points listed below:		
• The use of topical steroids or has a documented medical reason for not using this therapy to manage their medical condition.	☐	☐
• The use of a topical medication [i.e. Dovonex ® (calcipotriene), Tazorac ® (tazorotene), anthralin or a coal tar preparation] that is indicated for the treatment of psoriasis or has a documented medical reason for not using any of these therapies to manage their medical condition.	☐	☐
• The use of methotrexate or has a documented medical reason (e.g. history of liver or kidney disease, pregnancy, severe cytopenia, alcoholism) for not using this therapy to manage their medical condition.	☐	☐
• The use of cyclosporine or has a documented medical reason for not using this therapy to manage their medical condition.	☐	☐
• The use of Soriatane ® (acitretin) or has a documented medical reason for not using this therapy to manage their medical condition.	☐	☐
• The use of UVB phototherapy or PUVA (psoralen – oral or topical methoxsalen plus UVA therapy) or has a documented medical reason (e.g. pregnancy, skin cancer, hypersensitivity due to preexisting disease state - e.g. systemic lupus erythematus, cataracts) for not undergoing UVB phototherapy or PUVA to manage their medical condition.	☐	☐
Continuation of therapy for Plaque Psoriasis:		
Is the Patient tolerating treatment?	☐	☐
Is the medication being recommended and prescribed by a dermatologist for an FDA-approved indication at an FDA-approved dosage?	☐	☐
Documentation submitted indicates that the member has obtained clinical benefit from the medication?	☐	☐
Rheumatoid Arthritis:	☐	
The patient is an adult (≥18 y/o) and has a documented clinical diagnosis of rheumatoid arthritis (RA)?	☐	☐

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Does the patient have a documented (consistent with pharmacy claims data, OR for new members to the health plan consistent with medical chart history) adequate trial (including dates and doses) of 3 months or more of therapy with methotrexate AND then leflunomide (generic Arava®) or another disease-modifying antirheumatic drug (DMARD) option (i.e. combination therapy consisting of methotrexate + sulfasalazine or hydroxychloroquine) or has a documented medical reason (e.g. intolerance, hypersensitivity) for not utilizing any of these therapies to manage their medical condition?	☐	☐
The medication requested has an FDA approved indication for use in patients with rheumatoid arthritis and is being recommended and prescribed by a rheumatologist at an FDA-approved dosage?	☐	☐
Continuation of therapy for RA: Is the patient tolerating treatment?	☐	☐
Is the medication being recommended and prescribed by a rheumatologist for an FDA-approved indication at an FDA-approved dosage?	☐	☐
Documentation submitted indicates that the member has obtained clinical benefit from the medication?	☐	☐
Ankylosing Spondylitis:	☐	
Is the patient is an adult (≥18 years old) and has documented diagnosis of ankylosing spondylitis?	☐	☐
Does the patient have a documented (consistent with pharmacy claims data, OR for new members to the health plan consistent with medical chart history) adequate trial of or has a documented medical reason for not taking at least two nonsteroidal anti-inflammatory drugs (NSAIDS) to manage their medical condition?	☐	☐
Does the patient have a documented (consistent with pharmacy claims data, OR for new members to the health plan consistent with medical chart history) adequate trial of or has a documented medical reason for not taking a cyclo-oxygenase (COX)-2-selective inhibitors to manage their medical condition?	☐	☐
Is the medication requested have an FDA approved indication for use in patients with ankylosing spondylitis and is being recommended and prescribed by a rheumatologist at an FDA approved dosage?	☐	☐
Continuation of therapy for Ankylosing Spondylitis: Is the patient tolerating treatment?	☐	☐
Is the medication being recommended and prescribed by a rheumatologist for an FDA-approved indication at an FDA-approved dosage?	☐	☐
Documentation submitted indicates that the member has obtained clinical benefit from the medication?	☐	☐
Psoriatic Arthritis (PsA):	☐	

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Is the patient an adult (≥18 years old) and have a documented diagnosis of psoriatic arthritis?	☐	☐
Does the patient have a documented (consistent with pharmacy claims data, OR for new members to the health plan consistent with medical chart history) adequate trial of 2 g/day for 3 months of sulfasalazine or has a documented medical reason for not taking sulfasalazine (e.g. predominantly axial symptoms, hepatotoxicity, GI intolerance) to manage their medical condition?	☐	☐
Does the patient have a documented (consistent with pharmacy claims data, OR for new members to the health plan consistent with medical chart history) adequate trial (3 months without any improvement at maximum doses) of methotrexate or has another documented medical reason for not taking methotrexate (e.g. predominantly axial symptoms, liver toxicity) to manage their medical condition?	☐	☐
Is the medication requested have an FDA approved indication for use in patients with psoriatic arthritis and is being recommended and prescribed by a rheumatologist or a dermatologist at an FDA-approved dosage?	☐	☐
Continuation of therapy for Ankylosing Spondylitis: Is the patient tolerating treatment?	☐	☐
Is the medication being recommended and prescribed by a rheumatologist or dermatologist for an FDA-approved indication at an FDA-approved dosage?	☐	☐
Documentation submitted indicates that the member has obtained clinical benefit from the medication?	☐	☐

NOTE: THIS FORM MUST BE SIGNED BY A PHYSICIAN ☐

Signature of Requesting Provider:	**Date:**

Authorization is not a guarantee of payment. Member must be eligible at time of service.

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