Infliximab

Prior Authorization Request

CVS Caremark administers the medical drug prior authorization program on behalf of Harvard Pilgrim Health Care. Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to CVS Caremark, toll-free at 1-844-851-0882** to initiate the review process. If you have questions regarding the prior authorization please contact CVS Caremark at **1-844-387-1435.**

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____ **NPI#:** _____
Specialty: _____ **HPHC Provider ID**_____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Rendering Provider Info: ❑ **Same as Requesting Provider** **HPHC Provider ID:**_____
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____ **Provider Tax ID:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Drug Information:

*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un

*Directions(sig)*_____ *Route of administration*_____

*Dosing frequency*_____

Criteria Questions:

1. Which drug is being requested? ❑ Remicade ❑ Inflectra ❑ Renflexis ❑ Other

2. What is the diagnosis?
   - ❑ Crohn's disease
   - ❑ Ulcerative colitis
   - ❑ Rheumatoid arthritis
   - ❑ Ankylosing spondylitis
   - ❑ Axial spondyloarthritis
   - ❑ Psoriatic arthritis
   - ❑ Plaque psoriasis
   - ❑ Juvenile idiopathic arthritis (JIA)
   - ❑ Behçet's syndrome
   - ❑ Hidradenitis suppurativa
   - ❑ Pyoderma gangrenosum
   - ❑ Sarcoidosis
   - ❑ Takayasu's arteritis
   - ❑ Uveitis
   - ❑ Granulomatosis with polyangiitis (Wegener's granulomatosis)
   - ❑ Other _____

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-844-851-0882

3. What is the ICD-10 code? _____

4. Has the patient received the requested medication in a paid claim through a pharmacy or medical benefit in the previous 120 days? ❑ Yes ❑ No *If No, skip to #7*

5. How long has the patient been receiving the requested medication?
_____ weeks / months ***(circle one)***

6. Has the patient achieved or maintained positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms? ❑ Yes ❑ No *No Further Questions*

7. Has the patient received any of the following medications in a paid claim through a pharmacy or medical benefit in the previous 120 days? ***If Yes, please specify the most recent medication and skip to #9***

❑ Actemra	❑ Cimzia	❑ Cosentyx
❑ Enbrel	❑ Entyvio	❑ Humira
❑ Inflectra	❑ Kevzara	❑ Kineret
❑ Orencia	❑ Otezla	❑ Remicade
❑ Renflexis	❑ Rituxan	❑ Siliq
❑ Simponi	❑ Simponi Aria	❑ Stelara
❑ Taltz	❑ Tremfya	❑ Tysabri
❑ Xeljanz	❑ Xeljanz XR	❑ No

8. Has the patient undergone pretreatment screening for latent tuberculosis (TB) infection with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB)? ❑ Yes ❑ No

9. Is this request for Inflectra or Renflexis? ❑ Yes ❑ No *If No, skip to diagnosis section*

10. Has the patient previously received treatment with Remicade for the diagnosis designated in Question #2?
❑ Yes ❑ No *If No, skip to #12*

11. Has the patient experienced any of the following during treatment with Remicade?
Action Required: ***If yes, please attach supporting documentation***
❑ Yes – Inadequate response
❑ Yes – Intolerable adverse event (e.g., hypersensitivity reaction)
❑ No

12. Does the patient have a contraindication to Remicade?
Action Required: ***If yes, please attach supporting documentation*** ❑ Yes ❑ No

Complete the following section based on the patient's diagnosis.

Section A: Hidradenitis Suppurativa

13. Has the patient been diagnosed with severe, refractory hidradenitis suppurativa? ❑ Yes ❑ No

Section B: Crohn's Disease

14. Has the patient been diagnosed with moderately to severely active Crohn's disease? ❑ Yes ❑ No

15. Does the patient have fistulizing disease? *If Yes, no further questions* ❑ Yes ❑ No

16. Has the patient tried and had an inadequate response to at least one conventional therapy option (e.g., azathioprine [Azasan, Imuran], budesonide [Entocort EC], ciprofloxacin [Cipro], mesalamine [Asacol, Delzicol, Pentasa, Lialda], mercaptopurine [Purinethol], methylprednisolone [Solu-Medrol], methotrexate, metronidazole [Flagyl], prednisone, sulfasalazine [Azulfidine, Sulfazine], rifaximin [Xifaxan])? ❑ Yes ❑ No *If No, skip to #19*

17. Please indicate the previous treatment regimen: _____

18. Does the patient have a contraindication or intolerance to at least one conventional therapy option (e.g., azathioprine [Azasan, Imuran], budesonide [Entocort EC], ciprofloxacin [Cipro], mesalamine [Asacol, Delzicol, Pentasa, Lialda], mercaptopurine [Purinethol], methylprednisolone [Solu-Medrol], methotrexate, metronidazole [Flagyl], prednisone, sulfasalazine [Azulfidine, Sulfazine], rifaximin [Xifaxan])? ❑ Yes ❑ No

19. Please indicate the contraindication or intolerance: _____

Section C: Ulcerative Colitis

20. Has the patient been diagnosed with moderately to severely active ulcerative colitis? ❑ Yes ❑ No

21. Has the patient tried and had an inadequate response to at least one conventional therapy option (e.g., azathioprine [Azasan, Imuran], corticosteroid [e.g., budesonide, hydrocortisone, methylprednisolone, prednisone], cyclosporine [Sandimmune], mesalamine [Asacol, Lialda, Pentasa, Canasa, Rowasa], mercaptopurine [Purinethol], sulfasalazine, tacrolimus, metronidazole/ciprofloxacin [for pouchitis only])? ❑ Yes ❑ No *If No, skip to #23*

22. Please indicate the previous treatment regimen: _____

23. Does the patient have pouchitis? *If Yes, no further questions* ❑ Yes ❑ No

24. Does the patient have a contraindication or intolerance to at least one conventional therapy option (e.g., azathioprine [Azasan, Imuran], corticosteroid [e.g., budesonide, hydrocortisone, methylprednisolone, prednisone], cyclosporine [Sandimmune], mesalamine [Asacol, Lialda, Pentasa, Canasa, Rowasa], mercaptopurine [Purinethol], sulfasalazine, tacrolimus, metronidazole/ciprofloxacin [for pouchitis only])? ❑ Yes ❑ No

25. Please indicate the contraindication or intolerance: _____

Section D: Rheumatoid Arthritis

26. Has the patient been diagnosed with moderately to severely active rheumatoid arthritis? ❑ Yes ❑ No

27. Is the requested medication being prescribed in combination with methotrexate or leflunomide? *If Yes, no further questions* ❑ Yes ❑ No

28. Please indicate a clinical reason for the patient to not use methotrexate or leflunomide:

    _____ *No Further Questions*

29. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate? ❑ Yes ❑ No *If No, skip to #31*

30. What was the maximum titrated methotrexate dose? _____ mg per week

31. Has the patient experienced intolerance to methotrexate? *If Yes, no further questions* ❑ Yes ❑ No

32. Does the patient have a contraindication to methotrexate? ❑ Yes ❑ No

33. Please indicate the contraindication: _____

Section E: Ankylosing Spondylitis & Axial Spondyloarthritis

34. Has the patient been diagnosed with active ankylosing spondylitis (AS) or axial spondyloarthritis? ❑ Yes ❑ No

35. Has the patient experienced an inadequate response with at least TWO nonsteroidal anti-inflammatory drugs (NSAIDs) over a 4-week period in total at the maximum recommended or tolerated anti-inflammatory dose? *If Yes, no further questions* ❑ Yes ❑ No

36. Does the patient have intolerance or contraindication to at least two NSAIDs? ❑ Yes ❑ No

37. Please indicate the intolerance or contraindication to NSAIDs: _____

Section F: Psoriatic Arthritis

38. Has the patient been diagnosed with active psoriatic arthritis? ❑ Yes ❑ No

Section G: Plaque Psoriasis

39. Has the patient been diagnosed with chronic and severe plaque psoriasis? ❑ Yes ❑ No

40. What is the percentage of body surface area (BSA) affected? _____ %

41. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? ❑ Yes ❑ No

42. Has the patient experienced an inadequate response to phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine or acitretin? *If Yes, no further questions* ❑ Yes ❑ No

43. Has the patient had an intolerance or adverse event to a trial of phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine or acitretin? *If Yes, no further questions* ❑ Yes ❑ No

44. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine or acitretin? ❑ Yes ❑ No *If No, no further questions*

45. Please indicate clinical reason to avoid pharmacologic treatment: _____

Section H: Juvenile Idiopathic Arthritis

46. Has the patient been diagnosed with juvenile idiopathic arthritis (JIA)? ❑ Yes ❑ No

Section I: Uveitis

47. Has the patient had an inadequate response or intolerance, or has a contraindication to a trial of immunosuppressive therapy for uveitis (e.g., methotrexate, azathioprine, or mycophenolate mofetil)?
    - ❑ Yes - methotrexate
    - ❑ Yes - azathioprine
    - ❑ Yes - mycophenolate mofetil
    - ❑ Yes - Other
    - ❑ No

48. Please indicate medication(s) tried: _____

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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