BlueCross BlueShield Federal Employee Program

INFLIXIMAB PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
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:
Patient ID: **R**			Physician Signature:		

PHYSICIAN COMPLETES

NOTE: Form must be completed in its **entirety** for processing

Please select medication:

❑**Avsola (infliximab-axxq)** ❑**Infliximab** ❑**Renflexis (infliximab-abda)**
❑**Inflectra (infliximab-dyyb)** ❑**Remicade (infliximab)**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Has the patient been on the requested medication continuously for the last **4 months** for **Rheumatoid Arthritis OR** for the last **3 months** for **ALL other diagnoses** excluding samples? ***Please select answer below:***
   ❑**YES** - this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 3**
   ❑**NO** - this is **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Has the patient had a TB test prior to initiating therapy? ❑Yes* ❑No
   If YES, does the patient have an active or latent tuberculosis infection? ❑Active TB ❑Latent TB* ❑Test was negative
4. **If Latent TB Infection**: Has the patient started treatment for the infection prior to the use of this medication? ❑Yes ❑No
5. Does the patient have any active infections? ❑Yes ❑No
6. Is the patient at risk for hepatitis B virus (HBV) infection? ❑Yes* ❑No
   If YES, has hepatitis B virus (HBV) infection been ruled out or has the patient already started treatment for HBV infection? ❑Yes ❑No
7. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
8. **Requests for Avsola (infliximab-axxq) or Renflexis (infliximab-abda):** Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to **ONE** of the following medications: Inflectra, Infliximab, or Remicade? ❑Yes ❑No
9. Will the requested medication be used in combination with another biologic *DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify the medication: _____
   DMARDs: Actemra, Avsola, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Spevigo, Sotyktu, Stelara, Taltz, Tremfya, Truxima, Xeljanz
10. What is the patient's weight in either pounds or kilograms? _____ lbs **OR** _____ kg
11. Which dosing regimen is the patient on ***(specify dose and frequency)***? _____
12. What is the patient's diagnosis?
    ❑Behcet's syndrome ❑Sarcoidosis ❑Hidradenitis suppurativa (HS)
    ❑Pyoderma gangrenosum ❑Takayasu's arteritis ❑Granulomatosis w/polyangiitis (Wegener's granulomatosis)
    ❑Ankylosing spondylitis (AS) / axial spondyloarthritis
    a. Is the patient's condition active? ❑Yes ❑No
    b. Has the patient had an inadequate response to at least two non-steroidal anti-inflammatory drugs (NSAIDs) over a 4 week period in total at the maximum recommended or tolerated anti-inflammatory doses? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 – PHYSICIAN COMPLETES

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

❒Crohn's disease (CD)

a. Does the patient have moderate to severely active Crohn's disease (CD)? ❒Yes ❒No

b. **Age 6-17**: Will the patient be current on all vaccinations prior to initiating therapy? ❒Yes ❒No

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to conventional therapy for Crohn's disease (CD)? ❒Yes ❒No

❒Juvenile idiopathic arthritis (JIA)

a. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least a 3 month trial of a self-injectable TNF inhibitor for juvenile idiopathic arthritis (JIA)? ❒Yes ❒No

❒Plaque psoriasis (PsO)

a. Does the patient have severe plaque psoriasis that covers at least 5% of body surface area (BSA) or affects crucial body areas such as hands, feet, face, neck, scalp, genitals/groin, and intertriginous areas? ❒Yes ❒No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to conventional systemic therapy? ❒Yes***** ***(*If YES, please select one of the following below)*** ❒No

❒Inadequate response ❒Intolerance or contraindication ❒Has not tried conventional systemic therapy

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to phototherapy?

❒Inadequate response ❒Intolerance or contraindication ❒Has not tried phototherapy

❒Psoriatic arthritis (PsA)

a. Is the patient's psoriatic arthritis active? ❒Yes ❒No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3-month trial of at least one conventional DMARD? ❒Yes ❒No

❒Rheumatoid arthritis (RA)

a. Does the patient have moderate to severely active rheumatoid arthritis (RA)? ❒Yes ❒No

b. Has the patient had an inadequate response to at least a 3 month trial of methotrexate despite adequate dosing (i.e., titrated to 20mg/week)? ❒Yes ❒No*****

****If NO***, does the patient have a contraindication or intolerance to methotrexate? ❒Yes ❒No

c. Does the patient have a contraindication or intolerance to leflunomide? ❒Yes ❒No*****

****If NO***, will the patient receive concurrent therapy with either methotrexate or leflunomide? ❒Yes ❒No

❒Ulcerative colitis (UC)

a. Does the patient have moderate to severely active ulcerative colitis (UC)? ❒Yes ❒No

b. **Age 6-17**: Will the patient be current on all vaccinations prior to initiating therapy? ❒Yes ❒No

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to conventional therapy for ulcerative colitis (UC)? ❒Yes ❒No

❒Uveitis

a. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a trial of immunosuppressive therapy for uveitis? ❒Yes ❒No

❒Other diagnosis (***please specify***): _____

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Date:			Provider Name:		
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:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

CONTINUATION OF THERAPY (PA RENEWAL)

NOTE: Form must be completed in its **entirety** for processing

Please select medication:

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❑**Inflectra (infliximab-dyyb)** ❑**Remicade (infliximab)**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Has the patient been on the requested medication continuously for the last **4 months** for **Rheumatoid Arthritis OR** for the last **3 months** for **ALL other diagnoses** excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. What is the patient's diagnosis?
   ❑Ankylosing spondylitis (AS) / axial spondyloarthritis
   ❑Behcet's syndrome
   ❑Crohn's disease (CD)
   ❑Hidradenitis suppurativa (HS)
   ❑Granulomatosis w/polyangiitis (Wegener's granulomatosis)
   ❑Juvenile idiopathic arthritis (JIA)
   ❑Plaque psoriasis (PsO)
   ❑Psoriatic arthritis (PsA)
   ❑Pyoderma gangrenosum
   ❑Rheumatoid arthritis (RA)
   ❑Sarcoidosis
   ❑Takayasu's arteritis
   ❑Ulcerative colitis (UC)
   ❑Uveitis
   ❑Other ***(please specify)***: _____
4. Has the patient's condition improved or stabilized with therapy? ❑Yes ❑No
5. Does the patient have any active infections including tuberculosis (TB) and hepatitis B virus (HBV)? ❑Yes ❑No
6. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
7. Will the requested medication be used in combination with another biologic *DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   ****If YES***, please specify the medication: _____
   ****DMARDs: Actemra, Avsola, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Spevigo, Sotyktu, Stelara, Taltz, Tremfya, Truxima, and Xeljanz***
8. What is the patient's weight in either pounds or kilograms? _____ lbs **OR** _____ kg
9. Which dosing regimen is the patient on ***(specify dose and frequency)***? _____
10. Did the patient have an inadequate treatment response to the initial dosing regimen, and is therefore considered to be a non-responder? ❑Yes ❑No