Medical drug benefit
Prior authorization request

Avsola, Inflectra, Infliximab, Remicade or Renflexis
Version3.0 Effective: 06/21/2023

Phone: 877-417-1822 (MassHealth)
877-417-0528 (Clarity plans)
877-417-1839 (NH Medicaid)
Fax: 866-539-7185

* Some plans might not accept this form for Medicare or Medicaid requests

This form is being used for:	
Check if Expedited Review/Urgent Request:	☐ (In checking this box, I attest to the fact that this request meets the definition and criteria for expedited review and is an urgent request.)

1. Patient Information	
Patient Name:	DOB:
Member ID #:	

2. Prescriber Information	
Prescribing Clinician:	Phone #:
Specialty:	Secure Fax #:
NPI #:	DEA/xDEA:
Prescriber Point of Contact Name (POC) (if different than provider):	
POC Phone #:	POC Secure Fax #:
POC Email (not required):	
Prescribing Clinician or Authorized Representative Signature:	Date:

3. Drug Request	
Please select the drug you are requesting (select **one**):	
☐ Avsola (proceed to Q4, then Q5)	☐ Inflectra (proceed to Q4, then Q6)
☐ Infliximab (proceed to Q4, then Q6)	☐ Remicade (proceed ro Q4, then Q6)

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☐ Renflexis (proceed to Q4, then Q5)	

☐ Other (please specify):

4. Requested Dosing

Please document the requested dosing:

5. If the selected drug is Avsola, Renflexis, or Other in Q3:

If the selected drug is Avsola, Renflexis, or Other in Q3, please choose all of the following that apply:

☐ Member has tried one of Remicade or Inflectra

☐ Member cannot continue use with Remicade or Inflectra due to a formulation difference in the INACTIVE ingredient(s) that would result in a significant allergy or adverse effect (e.g., differences in stabilizing agent, buffering agent, and/or surfactant)

☐ Member is currently receiving requested agent for a condition other than plaque psoriasis

☐ Other clinical information (please specify):

6. Please choose all of the following that apply:

Please choose any of the following that apply:

☐ Ankylosing Spondylitis (Proceed to Q24)	☐ Behcet's Disease (Proceed to Q11)
☐ Crohn's Disease (Proceed to Q7)	☐ Graft-Versus-Host Disease (Proceed to Q12)
☐ Hidradenitis Suppurativa (Proceed to Q13)	☐ Immunotherapy-Related Toxicities Associated with Checkpoint Inhibitor Therapy (Proceed to Q14)
☐ Indeterminate Colitis (defined as colitis that cannot be classified with certainty as either ulcerative colitis or Crohn's disease (Proceed to Q15)	☐ Inflammatory Myopathies (polymyositis, dermatomyositis, inclusion body myositis)
☐ Juvenile Idiopathic Arthritis (JIA) (Proceed to Q16)	☐ Large vessel vasculitis (e.g., giant cell arteritis, Takayasu's arteritis)

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☐ Plaque Psoriasis (Proceed to Q8)	☐ Psoriatic Arthritis (Go to Q24)
☐ Pyoderma Gangrenosum (Proceed to Q17)	☐ Rheumatoid Arthritis (Proceed to Q9)
☐ Sarcoidosis (Proceed to Q18)	☐ Scleritis or Sterile Corneal Ulceration(Proceed to Q18)
☐ Spondyloarthritis, Other Subtypes (Proceed to Q20)	☐ Still's Disease(Proceed to Q22)
☐ Ulcerative Colitis (Proceed to Q10)	☐ Uveitis(Proceed to Q23)

☐ Other (please specify):

7. If the selected diagnosis is Crohn's Disease

Please choose **one** of the following that apply: (Proceed to Q24)

☐ Member has tried or is currently taking corticosteroids, or corticosteroids are contraindicated in this member

☐ Member has tried one other conventional systemic therapy for Crohn's disease (e.g azathioprine, 6-mercaptopurine, or methotrexate)

☐ Previous trial of a biologic agent

☐ Member has enterocutaneous (perianal or abdominal) or rectovaginal fistulas

☐ Member had ileocolonic resection (to reduce the chance of Crohn's disease recurrence)

☐ Other clinical information (please specify)

8. If the selected diagnosis is Plaque Psoriasis

Please choose **one** of the following that apply: (Proceed to Q24)

☐ Member has tried at least one traditional systemic agent for psoriasis for at least 3 months, unless intolerant (e. g. methotrexate, cyclosporine, acitretin (Soriatane®, generics), or psoralen plus ultraviolet A light (PUVA)

☐ Member had a 3-month trial or previous intolerance to at least one biologic agent

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☐ Member has a contraindication to methotrexate, as determined by the prescriber

☐ Other clinical information (please specify)

9. If the selected diagnosis is Rheumatoid Arthritis

Has the member tried ONE conventional synthetic disease-modifying antirheumatic drug (DMARD) for at least 3 months? (e.g., methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine) (Proceed to Q24)

☐ Yes

☐ No

10. If the selected diagnosis is Ulcerative Colitis

Please choose all of the following that apply (Proceed to Q24)

☐ Member had a trial of one systemic agent or was intolerant to one of the agents for ulcerative colitis (e.g. 6-mercaptopurine, azathioprine, cyclosporine, tacrolimus, or a corticosteroid)

☐ Member has pouchitis

☐ Member has tried therapy with an antibiotic (e.g metronidazole or ciprofloxacin), probiotic, corticosteroid enema, or Rowasa® (mesalamine enema)

11. If the selected diagnosis is Behcet's Disease

Please choose **one** of the following that apply (Proceed to Q24):

☐ Member has tried at least ONE conventional therapy (e.g systemic corticosteroids, azathioprine, methotrexate, mycophenolate mofetil, cyclosporine, tacrolimus, Leukeran®,cyclophosphamide, interferon alfa).

☐ Member has tried at least one tumor necrosis factor inhibitor (e.g., an adalimumab product, an etanercept product).

☐ Member has ophthalmic manifestations of Behcet's disease

12. If the selected diagnosis is Graft-Versus-Host Disease

Has the member tried at least one conventional systemic treatment for graft-versus-host disease? (e.g. methylprednisolone, antithymocyte globulin, cyclosporine, tacrolimus, and mycophenolate mofetil) (Proceed to Q24)

☐ Yes

☐ No

13. If the selected diagnosis is Hidradenitis Suppurativa

Has the member tried one other therapy (e.g. intralesional or oral corticosteroids (e.g., triamcinolone, prednisone), systemic antibiotics (e.g., clindamycin, dicloxacillin, erythromycin), and isotretinoin)? (Proceed to Q22)

☐ Yes

☐ No

14. If the selected diagnosis is Immunotherapy-related toxicities associated with Checkpoint Inhibitor Therapy

Please choose **all** of the following that apply (Proceed to Q24):

☐ Member developed an immunotherapy-related toxicity other than hepatitis

☐ Member developed this immune-related toxicity while receiving a checkpoint inhibitor

☐ Member has tried one systemic corticosteroid

☐ Other (please specify):

15. If the selected diagnosis is Indeterminate Colitis

Please choose all of the following that apply (Proceed to Q24):

☐ Member has tried one systemic corticosteroid

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☐ Member has tried mesalamine

☐ Member has tried either azathioprine or 6-mercaptopurine

☐ Other (please specify):

16. If the selected diagnosis is Juvenile Idiopathic Arthritis (JIA)

Please choose **one** of the following that apply (Proceed to Q24):

☐ Member has tried one other systemic medication for this condition (e.g methotrexate, sulfasalazine, or leflunomide, NSAIDs)

☐ Member has previously tried a biologic agent

☐ Member has aggressive disease, as determined by the prescriber

☐ Other (please specify):

17. If the selected diagnosis is Pyoderma Gangrenosum

Please choose **one** of the following that apply:

☐ Member has tried one systemic corticosteroid

☐ Member has tried one other immunosuppressant for at least 2 months or was intolerant to one of these medications (e.g., mycophenolate or cyclosporine)

☐ Other (please specify):

18. If the selected diagnosis is Sarcoidosis

Please choose **all** of the following that apply:

☐ Member has tried at least one systemic corticosteroid

☐ Member has tried at least one immunosuppressive medication (e.g methotrexate, azathioprine, cyclosporine, Leukeran® (chlorambucil tablet), Thalomid® (thalidomide capsules), or chloroquine

☐ Other (please specify):

19. If the selected diagnosis is Scleritis or Sterile Corneal Ulceration

Has the member tried one other therapy for this condition? (e.g., indomethacin; oral, ophthalmic or intravenous, methotrexate, cyclosporine or other immunosuppressants)?

☐ Yes

☐ No

20. If the selected diagnosis is Spondyloarthritis, Other Subtypes (e.g., Undifferentiated Arthritis, Non-Radiographic Axial Spondylitis, Reactive Arthritis [Reiter's Disease])

Please choose **one** of the following:

☐ Member has arthritis primarily in the knees, ankles, elbows, wrists, hands, and/or feet AND has tried at least ONE conventional synthetic disease-modifying antirheumatic drug (DMARD)

☐ Member has axial spondyloarthritis with objective signs of inflammation (Proceed to Q21)

☐ Other (please specify):

21. If the selected diagnosis is Axial Spondyloarthritis with Objective Signs of Inflammation

Please choose **one** of the following that apply (Proceed to Q24):

☐ C-reactive protein elevated beyond the upper limit of normal for the reporting laboratory

☐ Sacroilitis reported on magnetic resonance imaging

22. If the selected diagnosis is Still's Disease

Please choose all of the following that apply

☐ Member has tried one corticosteroid	☐ Member has tried one conventional synthetic disease-modifying antirheumatic drug (DMARD) given for at least 2 months or was intolerant (e.g. methotrexate)

☐ Other (please specify):

23. If the selected diagnosis is Uvelitis

Has the member tried periocular, intraocular, or systemic corticosteroids, or immunosuppressives therapies? (e.g. prednisolone, triamcinolone, betamethasone, methylprednisolone, prednisone, methotrexate, mycophenolate mofetil, and cyclosporine)

☐ Yes

☐ No

24. Specialty of the Prescriber

Please indicate what specialty the prescriber is (select any that apply):

☐ Dermatologist	☐ Gastroenterologist
☐ Ophthalmologist	☐ Oncologist
☐ Rheumatologist	☐ Transplant

Other (please indicate what specialty below):

25. Initial or Continuing Therapy

Is the request for initial or continuing therapy?

☐ Initial (proceed to Q28)

☐ Continuation (proceed to Q26)

26. For Continuing Therapy

For continuing therapy, has member had a response as determined by the prescriber?

☐ Yes (Proceed to Q27)

☐ No

27. Member's Response to Therapy

Please choose **all** of the following that apply:

☐ Decreased pain or stiffness	☐ Decreased joint pain, morning stiffness or fatigue
☐ Decreased soft tissue swelling in joints or tendon sheaths	☐ Decreased stool frequency or rectal bleeding
☐ Decreased inflammation	☐ Decreased eye pain, redness and photophobia
☐ Improved function or activities of daily living	☐ Improvements in acute phase reactants (for example, C-reactive protein)
☐ Improved laboratory values	☐ Improvement in visual acuity
☐ Reduced dosage of corticosteroids or immunomodulators	
☐ Other (please indicate below):	

28. HCPCS Codes

Please document the applicable HCPCS codes (e.g. J codes or Q codes) being requested, including the number of units and number of visits *(using the space below):*

☐ HCPCS / Qcodes:

☐ Number of units:

☐ Number of visits:

Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers may attach any additional data relevant to medical necessity criteria.

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