

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.

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? Yes No
- b. Does the patient have a contraindication or have they had either an inadequate response or intolerance to conventional therapy for Crohn's disease? Yes No

 Juvenile Idiopathic Arthritis (JIA)

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

 Plaque Psoriasis (Ps)

- 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 a contraindication or have they had either an inadequate response or intolerance 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 a contraindication to or have they had either an inadequate response or intolerance to phototherapy? Inadequate response Intolerance or contraindication Has not tried phototherapy

 Psoriatic Arthritis (PsA)

- a. Is the psoriatic arthritis active? Yes No
- b. Does the patient have a contraindication or have they had either an inadequate response or intolerance to a three month trial of at least one conventional disease-modifying antirheumatic drug (DMARD)? Yes No

 Rheumatoid Arthritis (RA)

- a. Does the patient have moderate to severely active rheumatoid arthritis? Yes No
- b. Has the patient had an inadequate response to at least a three-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? Yes No
- b. Does the patient have a contraindication or have they had either an inadequate response or intolerance to conventional therapy for ulcerative colitis? Yes No

 Uveitis

- a. Does the patient have a contraindication or have they had either an inadequate response or intolerance to a trial of immunosuppressive therapy? Yes No

 Other diagnosis (*please specify*): _____



BlueCross BlueShield

INFLIXIMAB

Federal Employee Program. PRIOR APPROVAL REQUEST

Send completed form to: FAX: 855-895-3504 FOR URGENT FAX: 844-244-0226

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Form with Patient Information and Provider Information sections, including fields for Date, Patient Name, Date of Birth, Sex, Street Address, City, State, Zip, Physician Signature, etc.

CONTINUATION OF THERAPY (PA RENEWAL)

NOTE: Form must be completed in its entirety for processing

Please select medication:

- Avsola (infliximab-axxq) Inflectra (infliximab-dyyb) Infliximab Renflexis (infliximab-abda)

**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
Granulomatosis w/polyangiitis (Wegener's granulomatosis)
Juvenile Idiopathic Arthritis (JIA)
Plaque Psoriasis (Ps)
Other diagnosis (please specify):
Psoriatic Arthritis (PsA)
Pyoderma gangrenosum
Rheumatoid Arthritis (RA)
Sarcoidosis
Takayasu's arteritis
Ulcerative Colitis (UC)
Uveitis

4. Has the patient's condition improved or stabilized? Yes No

5. Does the patient have any active infections including tuberculosis (TB) and hepatitis B (HBV)? Yes No

6. Will the patient be given live vaccines while on the requested medication? Yes No

7. Will the requested medication be used in combination with another biologic *disease-modifying antirheumatic drug (DMARD) or targeted synthetic DMARD? Yes* No

*If YES, please specify:

*DMARD includes: Actemra, Avsola, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Stelara, Taltz, Tremfya, Truxima, and Xeljanz

8. What is the patient's weight in either pounds or kilograms? lbs OR kg

9. What 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 a non-responder? Yes No

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. Prescriber Certification: I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Infliximab - FEP MD Fax Form Revised 1/7/2022