BlueCross BlueShield Federal Employee Program

(infliximab) REMICADE PRIOR APPROVAL REQUEST

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

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.

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

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
For Standard and Basic Option patients Avsola, Inflectra, Infliximab, Renflexis are preferred products. Please consider prescribing a preferred product. Standard/Basic Option patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year. The free pharmacy copays only apply to grandfathered members going through the pharmacy benefit.

Remicade (infliximab)

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

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

1. Has the patient been on Remicade 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. **Standard/Basic Option patient (for claims adjudicated through the pharmacy benefit):** Would you like to switch the patient to a preferred product? ❑Yes, Avsola ❑Yes, Inflectra ❑Yes, Infliximab ❑Yes, Renflexis ❑No, do not switch*
   If NO**, does the patient have an intolerance or contraindication or have they had an inadequate response to **TWO** of the following preferred products: Avsola, Inflectra, Infliximab, or Renflexis? ***Please select answer below:
   ❑**2 or More Drugs Tried** ***(specify drug(s) and result(s))***: _____
   _____
   ❑**1 Drug Tried** ***(specify drug and result(s))***: _____
   ❑**None Tried:** Is there a clinical reason for not trying the preferred products? ❑Yes* ❑No
   ***If YES**, please specify: _____
4. What is the patient's diagnosis?
   ❑Behcet's syndrome ❑Hidradenitis suppurativa ❑Sarcoidosis
   ❑Granulomatosis w/polyangiitis (Wegener's granulomatosis) ❑Pyoderma gangrenosum ❑Takayasu's arteritis
   ❑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 four-week period in total at the maximum recommended or tolerated anti-inflammatory doses? ❑Yes ❑No
   ❑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

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES AND INITIATION QUESTIONS

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PAGE 2 - PHYSICIAN COMPLETES

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

❒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 to or have they had either an inadequate response or intolerance to conventional systemic therapy? ***Please select answer below:***
❒Inadequate response ❒Intolerance or contraindication ❒Has not tried conventional systemic therapy

c. Does the patient have a contraindication 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***): _____

5. **Patient 6-17 Years of Age**: Will the patient be current on all vaccinations prior to initiating therapy? ❒Yes ❒No
6. Has the patient had a tuberculosis (TB) test prior to initiating therapy? ❒Yes***** ❒No
   ****If YES***, does the patient have an active or latent TB infection? ❒Active TB ❒Latent TB***** ❒Test was negative
   ****If Latent TB,*** has the patient started treatment for the infection prior to the use of Remicade? ❒Yes ❒No
7. Does the patient have any active infections? ❒Yes ❒No
8. Is the patient at risk for hepatitis B (HBV) infection? ❒Yes***** ❒No
   ****If YES***, has HBV been ruled out for this patient or has therapy been started for treatment of the HBV infection? ❒Yes ❒No
9. Will the patient be given live vaccines while on Remicade therapy? ❒Yes ❒No
10. Will Remicade 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, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Stelara, Taltz, Tremfya, Truxima, and Xeljanz***
11. What is the patient's weight in either pounds or kilograms? _____ lbs **OR** _____ kg
12. What dosing regimen is the patient on ***(specify dose and frequency)***? _____

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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

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CONTINUATION OF THERAPY (PA RENEWAL)

Remicade (infliximab)

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   ❑**1 Drug Tried** ***(specify drug and result(s))***: _____
   ❑**None Tried:** Is there a clinical reason for not trying the preferred products? ❑Yes* ❑No
   ***If YES**, please specify: _____
4. 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)
   ❑Psoriatic Arthritis (PsA)
   ❑Pyoderma gangrenosum
   ❑Rheumatoid Arthritis (RA)
   ❑Sarcoidosis
   ❑Takayasu's arteritis
   ❑Ulcerative Colitis (UC)
   ❑Uveitis
   ❑Other diagnosis ***(please specify)***: _____
5. Has the patient's condition improved or stabilized? ❑Yes ❑No
6. Does the patient have any active infections including tuberculosis (TB) and hepatitis B (HBV)? ❑Yes ❑No

PLEASE PROCEED TO PAGE 4 FOR ADDITIONAL CONTINUATION QUESTIONS

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PAGE 4 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R_____

7. Will the patient be given live vaccines while on Remicade? ❒Yes ❒No

8. Will Remicade be used in combination with another biologic ***disease-modifying antirheumatic drug **(**DMARD) or targeted synthetic DMARD? ❒Yes***** ❒No

   ****If YES***, please specify: _____

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

10. What dosing regimen is the patient on ***(specify dose and frequency)***? _____

11. Did the patient have an inadequate treatment response to the initial dosing regimen, and is therefore considered a non-responder? ❒Yes ❒No

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