Outpatient Medical Injectable Infliximab Authorization Request Form
Fax to 833-581-1861
(Medical Benefit Only)

Member Name: ________________________________ DOB: ____________________________

Member ID (UMI): ____ ☐ Medicare ☐ Commercial

Address: ____

ORDERING/ATTENDING PROVIDER

Physician Name: ______________________________ NPI: _____________________________

Address: ____

Office Contact: ________________ Phone Number: ______________ Fax Number: ______________

SITE OF CARE

<u>Place of Service *(please select one)*</u>

☐ Home Infusion ☐ Office – Professional ☐ Ambulatory Infusion Suite – Professional ☐ Outpatient Hospital

Is the site of care affiliated with a hospital or will the claim be billed as a facility claim? ☐ Yes ☐ No

Place of Service Name: _________________________ NPI: ______________ Tax ID: ____________

Address: ____

<u>Drug Supplier *(please select one)*</u>

☐ Supplied by a Specialty Pharmacy *(for Home Infusion, Office – Professional, or Ambulatory Infusion Suite – Professional)*
Pharmacy Name: ______________________________ Pharmacy NPI: ______________________________

☐ Buy & Bill *(for Office – Professional or Outpatient Hospital administration)*

DRUG INFORMATION *(please select one)*

<u>PREFERRED</u> <u>for</u> **<u>ALL indications</u>**	**<u>NON-PREFERRED**</u>**:
☐ **Avsola Q5121** ☐ **Inflectra Q5103** **<u>Medicare members</u> currently established on a non-preferred therapy are not required to try a preferred option	☐ Remicade J1745 ☐ Renflexis Q5104 **Has the member experienced a documented drug therapy failure or intolerance to the <u>preferred products?</u>** **Avsola:** ☐ **Yes** ☐ **No** **Inflectra:** ☐ **Yes** ☐ **No** **A non-preferred product will be considered when the member has a documented drug therapy failure after an adequate therapeutic trial, or intolerance, or contraindication to **BOTH** preferred products

****Please verify member's eligibility and benefits through the health plan****

DRUG INFORMATION *(continued)*

Drug Name: ___________________________Strength or Dose: _________________ Date(s) of service: _____________

Directions: ____Quantity (# of doses/visits): ____________

CLINICAL INFORMATION

Diagnosis code (ICD10): ____Member weight: ____________________

Diagnosis Description (check one)

☐ Ankylosing Spondylitis (AS)	☐ Non-infectious Uveitis	☐ Juvenile Rheumatoid Arthritis (JRA/JIA)
☐ Crohn's Disease (CD)	☐ Ulcerative Colitis (UC)	☐ Psoriatic Arthritis (PsA)
☐ Rheumatoid Arthritis (RA) ** Is Infliximab being used in combination with Methotrexate?* ☐ *YES* ☐ *NO* ** If NO, please explain:* ____		
☐ Other		

Does the member have moderate to severe disease? ____

List all previous therapies tried and failed ____

____

☐ **New Start**	☐ **Continuation of Therapy**
	Date of last infusion: ____ Has the member demonstrated disease stability or a beneficial response to therapy? ☐ YES ☐ NO

Please attach all pertinent clinical information

Attached: ☐ **YES** ☐ **NO**

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