

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

Place of Service (please select one)

☐ 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: _____

Phone Number: _____ Fax Number: _____

Drug Supplier (please select one)

☐ 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)

PREFERRED for ALL indications

☐ Avsola Q5121

☐ Inflectra Q5103

****Medicare members** currently established on a non-preferred therapy are not required to try a preferred option

NON-PREFERRED**

☐ Remicade J1745

☐ Renflexis Q5104

Has the member experienced a documented drug therapy failure or intolerance to the preferred products?

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**

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
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Please attach all pertinent clinical information**Attached:** ☐ YES ☐ NO

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