



**Outpatient Medical Injectable
Infliximab Authorization Request Form
Fax to 833-619-5745
(Medical Benefit Only)**

Member Name: _____ DOB: _____

Member UMI: _____ Medicare Commercial

Address: _____

REQUESTING PHYSICIAN INFORMATION

Physician Name: _____ NPI: _____

Address: _____

Office Contact: _____ Phone Number: _____ Fax Number: _____

SITE OF CARE

Place of Administration Name: _____ NPI: _____

Address: _____

Place of Administration Type (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

Drug Dispensing Information (please select one)

- Supplied by a Specialty Pharmacy (for Home Infusion, Office – Professional, or Ambulatory Infusion Suite – Professional)

Name: _____ 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**

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

Fax this completed form to Highmark at 1-833-619-5745

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