



**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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**DRUG INFORMATION (continued)**

Requested Drug Name: \_\_\_\_\_ Strength or Dose: \_\_\_\_\_

Directions: \_\_\_\_\_ Quantity (# of doses/visits): \_\_\_\_\_

**CLINICAL INFORMATION**

Diagnosis code (ICD10): \_\_\_\_\_ Member weight: \_\_\_\_\_

**Diagnosis Description (check one)**

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

Does the member have moderate to severe disease? \_\_\_\_\_

List all previous therapies tried and failed \_\_\_\_\_

<input type="checkbox"/> <b>New Start</b>	<input type="checkbox"/> <b>Continuation of Therapy</b>
	Date of last infusion: _____
	Has the member demonstrated disease stability or a beneficial response to therapy? <input type="checkbox"/> YES <input type="checkbox"/> NO

**Please attach all pertinent clinical information**Attached:     YES     NO**\*\*Please verify member's eligibility and benefits through the health plan\*\***

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