

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)

| <u>PREFERRED for ALL indications</u> | <u>NON-PREFERRED**</u> |
|---|---|
| <p><input type="checkbox"/> Avsola Q5121</p> <p><input type="checkbox"/> Inflectra Q5103</p> <p><small>**Medicare members currently established on a non-preferred therapy are not required to try a preferred option</small></p> | <p><input type="checkbox"/> Remicade J1745 <input type="checkbox"/> Renflexis Q5104</p> <p>Has the member experienced a documented drug therapy failure or intolerance to the preferred products?</p> <p>Avsola: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Inflectra: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><small>**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</small></p> |

****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)

| | | |
|--|--|--|
| <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) * Is Infliximab being used in combination with Methotrexate? <input type="checkbox"/> YES <input type="checkbox"/> NO * If NO, please explain: _____ | | |
| <input type="checkbox"/> Other | | |

Does the member have moderate to severe disease? _____

List all previous therapies tried and failed _____

| | |
|---|--|
| <input type="checkbox"/> New Start | <input type="checkbox"/> Continuation of Therapy 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 informationAttached: YES NO

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