HIGHMARK | HIGHMARK

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

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**	**NON-PREFERRED****
☐ **Avsola Q5121**	☐ Remicade J1745 ☐ Renflexis Q5104
☐ **Inflectra Q5103**	**Has the member experienced a documented drug therapy failure or intolerance to the preferred products?**
	Avsola: ☐ **Yes** ☐ **No**
	Inflectra: ☐ **Yes** ☐ **No**
**Medicare members currently established on a non-preferred therapy are not required to try a preferred option	**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