HIGHMARK NORTHEASTERN NEW YORK

# 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

**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)**

| | | |
|---|---|---|
| ☐ 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*<br>*** 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**<br>Date of last infusion: _____<br>Has the member demonstrated disease stability or a beneficial response to therapy? ☐ YES ☐ 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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