Pharmacy Prior Authorization

MERCY CARE (MEDICAID)

Renflexis (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Mercy Care at **1-800-854-7614**.
When conditions are met, we will authorize the coverage of Renflexis (Medicaid).

Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Renflexis (infliximab-adba)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Patient information

Patient name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis:_____ **ICD Code:**_____

Circle the appropriate answer for each question.

1. Has this plan authorized Renflexis in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 4.]

2. Is the prescribed dose within the FDA-approved dosing (based on weight)? Y N
   Please document current weight: _____

   [If no, then no further questions.]

3. Has the patient shown improvement in signs and symptoms of the disease? Y N

   [No further questions.]

4. Does the patient have a diagnosis of active moderate to severe rheumatoid arthritis (RA) (e.g., swollen, tender joints with limited range of motion)? Y N

   [If no, skip to question 8.]

5. Has the patient had an inadequate response to a three (3)-month trial of two different non-biologic disease modifying anti-rheumatic drug (DMARDs) regimens (one of which must include methotrexate)? Y N

   If yes, list medications tried: _____

   Note: Monotherapy regimen: methotrexate (MTX), leflunomide (LEF), sulfasalazine (SSZ).

   Combination regimen: MTX+SSZ+HCQ; MTX+HCQ, MTX+LEF, MTX+SSZ, SSZ+HCQ

   [If yes, skip to question 42.]

6. Does the patient have an intolerance or a contraindication to methotrexate? Y N

   Note: Contraindications include pregnancy, alcoholism, chronic liver disease, leukopenia, thrombocytopenia, or anemia.

   If yes, please document intolerance or contraindication: _____

   [If no, then no further questions]

7. Has the patient had an inadequate response to a three (3)-month trial of sulfasalazine or leflunomide? Y N

   [If yes, skip to question 42.]

   [If no, then no further questions.]

8. Does the patient have a diagnosis of ankylosing spondylitis (AS)? Y N

   [If no, skip to question 11.]

9. Has the patient had an inadequate response to a one (1) month trial of TWO non-steroidal anti-inflammatory drugs (NSAIDs) at an adequate dose? Y N

   If yes, please list medications tried:_____

   [If yes, skip to skip to question 42.]

10. Does the patient have a contraindication or intolerance to TWO oral NSAIDs? Y N

    Note: Contraindications such as true allergic reaction to NSAIDs, history of worsening asthma symptoms after taking aspirin or NSAIDs, current GI bleed,

severe renal dysfunction.

If yes, please document contraindication or intolerance: _____

[If yes, then skip to question 42.]

[If no, then no further questions.]

11. Does the patient have a diagnosis of plaque psoriasis? Y N

[If no, skip to question 17.]

12. Does the patient have more than 10% of body surface area affected by plaque psoriasis or has a PASI score of more than 10? Y N

[If yes, skip to question 14.]

13. Does the patient have less than 10% of body surface area affected by plaque psoriasis but has involvement of sensitive areas (i.e., hands, feet, face or genitals) that interferes with daily activities? Y N

[If no, then no further questions.]

14. Has phototherapy (UVB or PUVA) been ineffective? Y N

[If no, then no further questions.]

15. Has the patient had an inadequate response to a trial of least one oral systemic therapy such as methotrexate or cyclosporine for 3 months or more? Y N

[If yes, then skip to question 42.]

16. Does the patient have an intolerance or a contraindication to least one oral systemic therapy such as methotrexate or cyclosporine? Y N

Note: Contraindications such as pregnancy, alcoholism, chronic liver disease, leukopenia, thrombocytopenia, or anemia.

If yes, please document intolerance or contraindication: _____

[If yes, then skip to question 42.]

[If no, then no further questions.]

17. Does the patient have a diagnosis of psoriatic arthritis (PsA)? Y N

[If no, skip to question 25.]

18. Does the patient have predominately axial disease or active Y N

enthesitis/dactylitis?

[If no, skip to question 21.]

19. Has the patient had an inadequate response to a one (1) month trial of TWO non-steroidal anti-inflammatory drugs (NSAIDs)? Y N

    If yes, please list medications tried:_____

    [If yes, skip to skip to question 42.]

20. Does the patient have a contraindication or intolerance to TWO oral NSAIDs? Y N

    Note: Contraindications such as true allergic reaction to NSAIDs, history of worsening asthma symptoms after taking aspirin or NSAIDs, current GI bleed, severe renal dysfunction.

    If yes, please document contraindication or intolerance: _____

    [If yes, then skip to question 42.]

    [If no, then no further questions.]

21. Does the patient have active psoriatic arthritis (PsA)? Y N

    [If no, then skip to question 19.]

22. Has the patient had an inadequate response to a three (3)-month trial of methotrexate? Y N

    [If yes, skip to question 42.]

23. Does the patient have an intolerance or a contraindication to methotrexate? Y N

    Note: Contraindications such as pregnancy, alcoholism, chronic liver disease, leukopenia, thrombocytopenia, or anemia.

    If yes, please document intolerance or contraindication: _____

    [If no, then no further questions]

24. Has the patient had an inadequate response to a three (3)-month trial of sulfasalazine or leflunomide? Y N

    [If no, then no further questions.]

    [If yes, then skip to question 42.]

25. Does the patient have a diagnosis of Crohn's disease? Y N

[If no, skip to question 31.]

26. Has the patient had inadequate response or intolerable side effects to IV glucocorticoids after 7-10 days or to oral prednisone (dosed at 40 mg or more per day) after 30 days? Y N

    [If yes, skip to question 30.]

27. Does the patient have steroid-dependent Crohn's disease as evidenced by one of the following: A) Patient had a relapse within three months of stopping glucocorticoids; OR B) Patient is unable to taper steroids to an acceptable dose after 3 months without having symptom recurrence? Y N

    [If no, then no further questions.]

28. Has the patient had an inadequate response or intolerable side effects with a three (3)-month trial of mercaptopurine (6-MP), azathioprine (AZA), or injectable methotrexate? Y N

    [If yes, skip to question 30.]

29. Does the patient have a contraindication to all of the following: azathioprine (AZA), injectable methotrexate and mercaptopurine (6-MP)? Y N

    If yes, please document contraindication(s): _____

    [If no, then no further questions.]

30. Is the patient at least 6 years of age? Y N

    [If no, then no further questions.]

    [If yes, skip to question 41.]

31. Does the patient have a diagnosis of ulcerative colitis? Y N

    [If no, then no further questions.]

32. Has the patient had inadequate response or intolerable side effects to IV glucocorticoids after 7-10 days or to oral prednisone (dosed at 40 mg or more per day) after 30 days? Y N

    [If no, skip to question 37.]

33. Has the patient had a previous treatment failure with azathioprine (AZA) AND mercaptopurine (6-MP) OR has a contraindication to azathioprine and mercaptopurine? Y N

    If yes, please list medication tried and/or contraindications: _____

[If yes, skip to question 40.]

34. Has the patient had a surgical intervention for ulcerative colitis (UC)? Y N

[If yes, skip to question 40.]

35. Has the patient had an inadequate response or intolerable side effects to cyclosporine? Y N

[If yes, skip to question 40.]

36. Does the patient have a contraindication to cyclosporine? Y N

[If no, then no further questions.]

[If yes, skip to question 40.]

37. Does the patient have steroid-dependent ulcerative colitis as evidenced by one of the following: A) Patient had a relapse within three months of stopping corticosteroids; OR B) Patient is unable to taper steroids to an acceptable dose after 3 months without having symptom recurrence? Y N

[If no, then no further questions.]

38. Has the patient had an inadequate response or intolerable side effects with a three (3)-month trial of mercaptopurine (6-MP) or azathioprine (AZA)? Y N

[If yes, skip to question 40.]

39. Does the patient have a contraindication to azathioprine and mercaptopurine? Y N

[If no, then no further questions.]

40. Is the patient at least 18 years of age? Y N

[If no, then no further questions.]

41. Has the patient tried and failed Humira? Y N

[If yes, skip to question 44.]

[If no, then no further questions.]

42. Has the patient tried and failed BOTH Enbrel and Humira? Y N

[If no, then no further questions.]

43. Is the patient at least 18 years of age? Y N

[If no, then no further questions.]

44. Is Renflexis being prescribed by, or in consultation with a specialist, based on indication (rheumatologist, dermatologist, or gastroenterologist)? Y N

    [If no, then no further questions.]

45. Has the patient been screened for latent tuberculosis (TB) and hepatitis B? Y N

    [If no, then no further questions.]

46. Does the patient have latent tuberculosis (TB) and/or active or chronic Hepatitis B infection? Y N

    [If no, skip to question 47.]

47. Is the patient currently receiving or has completed treatment for latent TB infection or Hepatitis B? Y N

    [If no, then no further questions.]

48. Will Renflexis be given in combination with another cytokine or cell adhesion molecule (CAM) antagonist? Y N

    [If yes, then no further questions.]

49. Has the patient been evaluated for and given the appropriate vaccinations as recommended per the Centers for Disease Control and Prevention (CDC) for his/her risk factors? Y N

    [If no, then no further questions.]

50. Does the patient have CHF (NYHA class III or IV)? Y N

    [If yes, then no further questions.]

51. Is the prescribed dose within the FDA-approved dosing (based on weight)? Y N
    Please document current weight: _____

Comments:

_____

_____

I affirm that the information given on this form is true and accurate as of this date.

_____

Prescriber (Or Authorized) Signature **Date**