



MEDICARE FORM

Avsola™ (infliximab-axxq) Injectable Medication Precertification Request

Page 1 of 5

(All fields must be completed and legible for precertification review.)

For Medicare Advantage Part B:

FAX: 1-844-268-7263

PHONE: 1-866-503-0857

For other lines of business:

Please use other form.

Note: Avsola is preferred for MA plans. Preferred status for MAPD plans varies based on indication. See section G below.

Please indicate: Start of treatment: Start date ____/____/____
 Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ **Phone:** _____ **Fax:** _____

A. PATIENT INFORMATION

| | | | |
|--|-------------|-----------------------------------|-------------|
| First Name: | | Last Name: | |
| Address: | | City: | State: ZIP: |
| Home Phone: | Work Phone: | Cell Phone: | |
| DOB: | Allergies: | E-mail: | |
| Current Weight: _____ lbs or _____ kgs | | Height: _____ inches or _____ cms | |

B. INSURANCE INFORMATION

| | |
|--|--|
| Aetna Member ID #: _____ | Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Group #: _____ | If yes, provide ID#: _____ Carrier Name: _____ |
| Insured: _____ | Insured: _____ |
| Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____ | Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____ |

C. PRESCRIBER INFORMATION

| | | | |
|---|---|-----------|---------------------|
| First Name: | Last Name: (Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A. | | |
| Address: | City: | State: | ZIP: |
| Phone: | Fax: | St Lic #: | NPI #: DEA #: UPIN: |
| Provider E-mail: | Office Contact Name: | | Phone: |
| Specialty (Check one): <input type="checkbox"/> Dermatologist <input type="checkbox"/> Gastroenterologist <input type="checkbox"/> Rheumatologist <input type="checkbox"/> Other: _____ | | | |

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

| | |
|--|--|
| Place of Administration: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____ NPI: _____ | Dispensing Provider/Pharmacy: Patient Selected choice <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other _____ Name: _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____ NPI: _____ |
|--|--|

E. PRODUCT INFORMATION

Request is for: Avsola (infliximab-axxq) Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (clinical documentation required for all requests):

Note: Avsola, Entyvio, Remicade, and Simponi Aria are preferred for MA plans. For MAPD plans, Avsola, Entyvio, and Remicade, are preferred for ulcerative colitis and Enbrel, Humira, Otezla, Rinvoq, Skyrizi, and Xeljanz/Xeljanz XR are preferred for other indications. Preferred products vary based on indication.

Yes No Has the patient had prior therapy with Avsola (infliximab-axxq) within the last 365 days?

Yes No Has the patient had a trial, intolerance, or contraindication to any of the following? (select all that apply)

Enbrel (etanercept) Humira (adalimumab) Otezla (apremilast) Rinvoq (upadacitinib) Skyrizi (risankizumab-rzaa)

Xeljanz/Xeljanz XR (tofacitinib)

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all the apply)

Enbrel (etanercept) Humira (adalimumab) Otezla (apremilast) Rinvoq (upadacitinib) Skyrizi (risankizumab-rzaa)

Xeljanz/Xeljanz XR (tofacitinib)

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G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

Yes No Will the requested drug be used in combination with any other biologic or targeted synthetic disease-modifying anti-rheumatic drug (DMARD) (e.g., Olumiant, Xeljanz)?

Yes No Has the patient received a biologic or targeted synthetic DMARD (e.g., Rinvoq, Xeljanz) in the past?

Yes No Has the patient been tested for TB with a PPD test, interferon-release assay (IGRA) or chest x-ray within 6 months of initiating a biologic therapy?

(Check all that apply): PPD test interferon-gamma assay (IGRA) chest x-ray
Please enter the results of the TB test: positive negative unknown
If positive, Does the patient have latent or active TB? latent active unknown
If latent TB, Yes No Has treatment for latent tuberculosis (TB) infection been initiated or completed?
Please select: treatment initiated treatment completed

Yes No Does the patient have risk factors for TB?

Yes No Has the patient been tested for tuberculosis (TB) within the previous 12 months?

(Check all that apply): PPD test interferon-gamma assay (IGRA) chest x-ray
Please enter the results of the TB test: positive negative unknown
If positive, Does the patient have latent or active TB? latent active unknown
If latent TB, Yes No Has treatment for latent tuberculosis (TB) infection been initiated or completed?
Please select: treatment initiated treatment completed

For Initiation Requests:

Ankylosing spondylitis or axial spondyloarthritis

Please select which of the following applies to the patient: Active ankylosing spondylitis (AS) Active axial spondyloarthritis

Yes No Has the patient previously received a biologic indicated for active ankylosing spondylitis?

Yes No Has the patient experienced an inadequate response with at least TWO nonsteroidal anti-inflammatory drugs (NSAIDs), or has an intolerance or contraindication to at least two NSAIDs?

Please indicate the preferred alternatives for ankylosing spondylitis (AS) or axial spondyloarthritis that have been ineffective, not tolerated, or are contraindicated:
 Cosentyx Enbrel Humira Remicade Simponi Aria

Behçet's syndrome

Yes No Has the patient received Otezla or a biologic indicated for the treatment of Behçet's disease?

Yes No Has the patient had an inadequate response to at least one nonbiologic medication for Behçet's disease (e.g., colchicine, systemic glucocorticoids, azathioprine)?

Crohn's disease

Yes No Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)?

Yes No Does the patient have fistulizing Crohn's disease?

Yes No Has the patient previously received a biologic indicated for moderately to severely active Crohn's disease?

Yes No Has the patient tried and had an inadequate response to at least one conventional therapy option?

Yes No Does the patient have a contraindication or intolerance to at least one conventional therapy option (e.g., azathioprine [Azasan, Imuran], budesonide [Entocort EC], ciprofloxacin [Cipro], mercaptopurine [Purinethol], methylprednisolone [Solu-Medrol], methotrexate, metronidazole [Flagyl], prednisone, sulfasalazine [Azulfidine, Sulfazine], rifaximin [Xifaxan], tacrolimus)?

Please select: Sulfasalazine (Azulfidine, Sulfazine) Metronidazole (Flagyl) Ciprofloxacin (Cipro) Prednisone Budesonide (Entocort EC) Azathioprine (Azasan, Imuran) Mercaptopurine (Purinethol) Methotrexate Methylprednisolone (Solu-Medrol) Rifaximin (Xifaxan) Tacrolimus

Please indicate the preferred alternatives for Crohn's disease that have been ineffective, not tolerated, or are contraindicated:
 Humira Entyvio Remicade Stelara (intravenous formulation)

Granulomatosis with polyangiitis (Wegener's granulomatosis)

Yes No Has the patient experienced an inadequate response with corticosteroids or immunosuppressive therapy (e.g., cyclophosphamide, azathioprine, methotrexate, or mycophenolate mofetil)?

Yes No Has the patient experienced an intolerance to corticosteroids and immunosuppressive therapy (e.g., cyclophosphamide, azathioprine, methotrexate, or mycophenolate mofetil)?

Yes No Does the patient have a contraindication to corticosteroids and immunosuppressive therapy (e.g., cyclophosphamide, azathioprine, methotrexate, or mycophenolate mofetil)?

Hidradenitis suppurativa

Yes No Has the patient been diagnosed with severe, refractory hidradenitis suppurativa?

Yes No Has the patient previously received a biologic medication indicated for the treatment of severe, refractory hidradenitis suppurativa?

Yes No Has the patient experienced an inadequate response after at least 90 days of treatment with oral antibiotics?

Yes No Has the patient experienced an intolerable adverse effect to oral antibiotics?

Yes No Does the patient have a contraindication to oral antibiotics?

Yes No Has the patient had an ineffective response, contraindication or intolerance to Humira?

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G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

Juvenile idiopathic arthritis

- Yes No Has the patient previously received a biologic indicated for juvenile idiopathic arthritis?
 - Yes No Has the patient experienced an inadequate response to ANY of the following?
 - Please select: At least 1-month trial of NSAIDs At least 2 weeks of treatment with corticosteroids (e.g., prednisone, methylprednisolone) At least 3 months of treatment with methotrexate At least 3 months of treatment with leflunomide
- Yes No Has the patient had an ineffective response, contraindication or intolerance to Humira?
- Yes No Has the patient had an ineffective response, contraindication or intolerance to Enbrel?

Immune checkpoint inhibitor toxicity

- Yes No Has the patient experienced an inadequate response to corticosteroids?
 - Yes No Does the patient have cardiac toxicity?

Plaque psoriasis

- Yes No Has the patient been diagnosed with chronic, severe plaque psoriasis?
- Yes No Has the patient previously received Otezla or any other biologic medication indicated for the treatment of chronic, severe plaque psoriasis?
 - What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)?
 - Please select: Less than 3% of BSA
 - Yes No Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected?
 - Greater than or equal to 3% of BSA
 - Yes No Has the patient experienced an inadequate response, or has an intolerance to phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine or acitretin?
 - Yes No Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine and acitretin?
 - Yes No Does the patient have severe psoriasis that warrants a biologic DMARD as first-line therapy (i.e. at least 10% of the body surface area (BSA) or crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected)?
- Please indicate clinical reason to avoid pharmacologic treatment: Alcoholism, alcoholic liver disease or other chronic liver disease Breastfeeding Cannot be used due to risk of treatment-related toxicity Drug interaction with traditional systemic agent Pregnancy or planning pregnancy Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension) Other reason to avoid pharmacologic treatment
 - Yes No Does the patient have severe psoriasis that warrants a biologic DMARD as first-line therapy (i.e. at least 10% of the body surface area (BSA) or crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected)?

Please indicate the preferred alternatives for plaque psoriasis that have been ineffective, not tolerated, or are contraindicated:

- Humira Ilumya Otezla Remicade Skyrizi Stelara Taltz Tremfya

Psoriatic arthritis

- Yes No Has the patient been diagnosed with active psoriatic arthritis (PsA)?
- Please indicate the preferred alternatives for psoriatic arthritis that have been ineffective, not tolerated, or are contraindicated:
 - Cosentyx Enbrel Humira Otezla Remicade Simponi Aria

Pyoderma gangrenosum

- Yes No Has the patient previously received a biologic medication indicated for the treatment of pyoderma gangrenosum?
 - Yes No Has the patient experienced an inadequate response with corticosteroids or immunosuppressive therapy (e.g., cyclosporine or mycophenolate mofetil)?
 - Yes No Has the patient experienced an intolerance to corticosteroids and immunosuppressive therapy (e.g., cyclosporine or mycophenolate mofetil)?
 - Yes No Does the patient have a contraindication to corticosteroids and immunosuppressive therapy (e.g., cyclosporine mycophenolate mofetil)?

Reactive arthritis

- Yes No Has the patient previously received a biologic medication indicated for the treatment of reactive arthritis?
 - Yes No Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate titrated 20 mg per week?
 - Yes No Has the patient experienced intolerance to methotrexate?
 - Yes No Does the patient have a contraindication to methotrexate?
 - Please indicate the contraindication: History of intolerance or adverse event Alcoholism, alcoholic liver disease or other chronic liver disease Elevated liver transaminases Interstitial pneumonitis or clinically significant pulmonary fibrosis Renal impairment Pregnancy or planning pregnancy Breastfeeding Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia) Myelodysplasia Hypersensitivity Significant drug interaction Other

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G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

Rheumatoid arthritis

Yes No Has the patient been diagnosed with moderately to severely active rheumatoid arthritis (RA)?

Yes No Has the patient previously received a biologic or targeted synthetic disease modifying drug (e.g., Xeljanz) indicated for moderately to severely active rheumatoid arthritis?

Yes No Is the requested medication being prescribed in combination with methotrexate or leflunomide?

 Please indicate a clinical reason for the patient to not use methotrexate or leflunomide: History of intolerance or adverse event Alcoholism, alcoholic liver disease or other chronic liver disease Elevated liver transaminases Interstitial pneumonitis or clinically significant pulmonary fibrosis Renal impairment Pregnancy or planning pregnancy Breastfeeding Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia) Myelodysplasia Hypersensitivity Significant drug interaction

Yes No Does the patient have other reason or no clinical reason not to use methotrexate or leflunomide? Please explain: _____

Yes No Has the patient experienced an inadequate response after at least 3 months of treatment with the methotrexate dose greater than or equal to 20 mg per week?

Yes No Has the patient experienced intolerance to methotrexate?

Yes No Does the patient have a contraindication to methotrexate?

 Please indicate the contraindication:
 History of intolerance or adverse event
 Alcoholism, alcoholic liver disease or other chronic liver disease
 Elevated liver transaminases Interstitial pneumonitis or clinically significant pulmonary fibrosis Renal impairment Pregnancy or planning pregnancy Breastfeeding Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia) Myelodysplasia Hypersensitivity Significant drug interaction Other No clinical reason not to use methotrexate or leflunomide

Yes No Is the requested medication being prescribed in combination with methotrexate or leflunomide?

 Please indicate a clinical reason for the patient to not use methotrexate or leflunomide: History of intolerance or adverse event Alcoholism, alcoholic liver disease or other chronic liver disease Elevated liver transaminases Interstitial pneumonitis or clinically significant pulmonary fibrosis Renal impairment Pregnancy or planning pregnancy Breastfeeding Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia) Myelodysplasia Hypersensitivity Significant drug interaction Other No clinical reason not to use methotrexate or leflunomide

Please indicate the preferred alternatives for rheumatoid arthritis have been ineffective, not tolerated, or are contraindicated:

- Enbrel Humira Kevzara Orencia Remicade Rinvoq Simponi Aria Xeljanz/Xeljanz XR

Sarcoidosis

Yes No Has the patient experienced an inadequate response with corticosteroids or immunosuppressive therapy?

Yes No Has the patient experienced an intolerance to corticosteroids and immunosuppressive therapy?

Yes No Does the patient have a contraindication to corticosteroids and immunosuppressive therapy?

Takayasu's arteritis

Yes No Has the patient experienced an inadequate response with corticosteroids or immunosuppressive therapy (e.g., methotrexate, azathioprine, or mycophenolate mofetil)?

Yes No Has the patient experienced an intolerance to corticosteroids and immunosuppressive therapy (e.g., methotrexate, azathioprine, or mycophenolate mofetil)?

Yes No Does the patient have a contraindication to corticosteroids and immunosuppressive therapy (e.g., methotrexate, azathioprine, or mycophenolate mofetil)?

Ulcerative colitis

Yes No Has the patient been diagnosed with moderately to severely active ulcerative colitis (UC)?

Yes No Has the patient been hospitalized for fulminant ulcerative colitis (e.g., continuous bleeding, severe toxic symptoms, including fever and anorexia)?

Yes No Has the patient previously received a biologic or targeted synthetic disease modifying drug (e.g., Xeljanz) indicated for moderately to severely active ulcerative colitis?

Yes No Has the patient tried and had an inadequate response to at least one conventional therapy option?

Yes No Does the patient have a contraindication or intolerance to at least one conventional therapy option (e.g., azathioprine [Azasan, Imuran], corticosteroid [e.g., budesonide, hydrocortisone [Entocort, Uceris], methylprednisolone, prednisone, cyclosporine [Sandimmune], mesalamine [Asacol, Lialda, Pentasa, Canasa, Rowasa], mercaptopurine [Purinethol], sulfasalazine, tacrolimus [Prograf], metronidazole/ciprofloxacin [for pouchitis only])?

 Please select: Azathioprine (Azasan, Imuran) Corticosteroid (e.g., budesonide [Entocort, Uceris], hydrocortisone [Cortifoam, Colocort, Solu-Cortef, Cortef], methylprednisolone [Medrol, Solu-Medrol], prednisone) Cyclosporine (Sandimmune) Mesalamine (e.g., Apriso, Asacol, Lialda, Pentas, Canasa, Rowasa) Mercaptopurine (Purinethol) Sulfasalazine Tacrolimus (Prograf) Metronidazole (Flagyl) or Ciprofloxacin (Cipro) (for pouchitis only)

Please indicate the preferred alternatives for ulcerative colitis that have been ineffective, not tolerated, or are contraindicated:

- Humira Entyvio Remicade Xeljanz Stelara (intravenous formulation)



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G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

Uveitis

Yes No Has the patient previously received a biologic medication indicated for the treatment of uveitis?

Yes No Has the patient experienced an inadequate response with corticosteroids or immunosuppressive therapy (e.g., methotrexate, azathioprine, or mycophenolate mofetil)?

Yes No Has the patient experienced an intolerance to corticosteroids and immunosuppressive therapy (e.g., methotrexate, azathioprine, or mycophenolate mofetil)?

Yes No Does the patient have a contraindication to corticosteroids and immunosuppressive therapy (e.g., methotrexate, azathioprine, or mycophenolate mofetil)?

Yes No Has the patient had an ineffective response, contraindication or intolerance to Humira?

For Continuation Requests:

Yes No Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

Yes No Has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms since starting treatment with the requested drug?

H. ACKNOWLEDGEMENT

Request Completed By (Signature Required): _____ **Date:** ____ / ____ / ____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.