



Inflectra® (infliximab-dyyb) Injectable Medication Precertification Request

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

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

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:	E-mail:	
Current Weight: ____ lbs or ____ kgs		Height: ____ inches or ____ cms		Allergies:	

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): Dermatologist Gastroenterologist Rheumatologist 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: _____	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: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____
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E. PRODUCT INFORMATION

Request is for: **Inflectra (infliximab-dyyb)** 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):

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

Yes No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic DMARD (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis (TB)?

Yes No Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [PPD], interferon-release assay [IGRA], chest x-ray) within 6 months of initiating therapy?

 (Check all that apply): PPD test interferon-gamma assay (IGRA) chest x-ray

 Please enter the results of the tuberculosis (TB) test: positive negative unknown

If positive, please indicate which applies to the patient:

latent TB and treatment for latent TB has been initiated

latent TB and treatment for latent TB has been completed

latent TB and treatment for latent TB has not been initiated

active TB

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

Yes No Is this infusion request in an outpatient hospital setting?

Yes No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g., acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?

Yes No Has the patient developed antibodies to infliximab which increases the risk for infusion related reactions?

Yes No Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?

Yes No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?

→ Please provide a description of the behavioral issue or impairment: _____

Yes No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?

→ Please provide a description of the condition: Cardiopulmonary: _____
 Respiratory: _____
 Renal: _____
 Other: _____

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

Acute graft versus host disease

Yes No Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?

Yes No Has the patient experienced an inadequate response to systemic corticosteroids?

→ Yes No Does the patient have an intolerance or contraindication to corticosteroids?

Ankylosing spondylitis and axial spondyloarthritis

Please indicate loading dose at weeks 0, 2 and 6: _____ Please indicate maintenance dose: _____ frequency: _____ weeks

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

Yes No Has the patient ever received (including current utilizers) a biologic (e.g., Cimzia) indicated for active ankylosing spondylitis or active axial spondyloarthritis?

→ 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?

Behçet's disease

Yes No Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?

Yes No Has the patient ever received (including current utilizers) Otezla or a biologic (e.g., Humira) 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., apremilast, colchicine, systemic glucocorticoids, azathioprine)?

Crohn's disease

Please indicate loading dose at weeks 0, 2 and 6: _____ Please indicate maintenance dose: _____ frequency: _____ weeks

Yes No Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?

→ Please select: Supported by the manufacturer's prescribing information
→ Yes No Is the requested dose and frequency supported by the manufacturer's prescribing information for the patient's diagnosis?

Supported by dosing guidelines found in the compendia or current literature
→ Yes No Is the supporting information attached?

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

Yes No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for moderately to severely active Crohn's disease?

→ Yes No Does the patient have fistulizing 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 IM or SC, 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 IM or SQ Methylprednisolone (Solu-Medrol) Rifaximin (Xifaxan)
 Tacrolimus

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

Granulomatosis with polyangiitis (Wegener's granulomatosis)

- Yes No Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?
- Yes No Has the patient experienced an inadequate response with corticosteroids or immunosuppressive therapy (e.g., cyclophosphamide, azathioprine, methotrexate, mycophenolate mofetil)?
 - Yes No Has the patient experienced an intolerance to corticosteroids and immunosuppressive therapy (e.g., cyclophosphamide, azathioprine, methotrexate, mycophenolate mofetil)?
 - Yes No Does the patient have a contraindication to corticosteroids and immunosuppressive therapy (e.g., cyclophosphamide, azathioprine, methotrexate, mycophenolate mofetil)?

Hidradenitis suppurativa

- Yes No Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?
- Yes No Has the patient been diagnosed with severe, refractory hidradenitis suppurativa?
- Yes No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) 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?

Juvenile idiopathic arthritis

- Yes No Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?
- Yes No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic disease-modifying antirheumatic drug (DMARD) 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

Immune checkpoint inhibitor (e.g., CTLA-4, PD-L1 inhibitor) toxicity

- Yes No Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?
- Yes No Has the patient experienced an inadequate response to corticosteroids?
 - Yes No Has the patient experienced an intolerance to corticosteroids?
 - Yes No Does the patient have a contraindication to corticosteroids?
 - Yes No Does the patient have cardiac toxicity?
 - Yes No Does the patient have moderate or severe diarrhea or colitis?

Plaque psoriasis

- Please indicate loading dose at weeks 0, 2 and 6: _____ Please indicate maintenance dose: _____ frequency: _____ weeks
- Yes No Has the patient been diagnosed with moderate to severe plaque psoriasis?
 - Yes No Has the patient ever received (including current utilizers) Otezla or a biologic (e.g., Humira) indicated for the treatment of moderate to severe plaque psoriasis?
 - Yes No Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected?
 - Please indicate the percentage of body surface area (BSA) affected (prior to starting the requested medication): _____ %
 - If less than 10% 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?
 - Please indicate clinical reason to avoid pharmacologic treatment: Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease Breastfeeding Cannot be used due to risk of treatment-related toxicity Drug interaction Pregnancy or currently planning pregnancy Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension) Other, please explain: _____

Psoriatic arthritis

- Please indicate loading dose at weeks 0, 2 and 6: _____ Please indicate maintenance dose: _____ frequency: _____ weeks
- Yes No Has the patient been diagnosed with active psoriatic arthritis (PsA)?
 - Please indicate which of the following applies to the patient: WITH co-existent plaque psoriasis WITHOUT co-existent plaque psoriasis

Pyoderma gangrenosum

- Yes No Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?
- Yes No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for the treatment of pyoderma gangrenosum?
 - Yes No Has the patient experienced an inadequate response with corticosteroids or immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)?
 - Yes No Has the patient experienced an intolerance to corticosteroids and immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)?
 - Yes No Does the patient have a contraindication to corticosteroids and immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)?

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

Reactive arthritis

Yes No Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?

Yes No Has the patient ever received (including current utilizers) a biologic (e.g., Enbrel) 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 at a dose greater than or equal to 15 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
 Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease
 Elevated liver transaminases Interstitial pneumonitis or clinically significant pulmonary fibrosis
 Renal impairment Pregnancy or currently planning pregnancy
 Breastfeeding Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
 Myelodysplasia Hypersensitivity Significant drug interaction
 Other, please explain: _____

Rheumatoid arthritis

Please indicate loading dose at weeks 0, 2 and 6: _____ Please indicate maintenance dose: _____ frequency: _____ weeks

Yes No Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?

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

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

Yes No Does the patient meet either of the following: a) the patient was tested for the rheumatoid factor (RF) biomarker and the RF biomarker test was positive, or b) the patient was tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker and the anti-CCP biomarker test was positive?

Yes No Has the patient been tested for all of the following biomarkers: a) rheumatoid factor (RF), b) anti-cyclic citrullinated peptide (anti-CCP), and c) C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR)?

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
 Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease
 Elevated liver transaminases Interstitial pneumonitis or clinically significant pulmonary fibrosis
 Renal impairment Pregnancy or currently planning pregnancy
 Breastfeeding Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
 Myelodysplasia Hypersensitivity Significant drug interaction
 Other, please explain: _____

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

Yes No Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate at a dose greater than or equal to 15 mg per week?

Yes No Has the patient experienced an intolerance to methotrexate?

Yes No Does the patient have a contraindication to methotrexate?

Please indicate the contraindication: History of intolerance or adverse event Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease
 Elevated liver transaminases Interstitial pneumonitis or clinically significant pulmonary fibrosis
 Renal impairment Pregnancy or currently planning pregnancy
 Breastfeeding Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
 Myelodysplasia Hypersensitivity Significant drug interaction
 Other, please explain: _____

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
 Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease
 Elevated liver transaminases Interstitial pneumonitis or clinically significant pulmonary fibrosis
 Renal impairment Pregnancy or currently planning pregnancy
 Breastfeeding Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
 Myelodysplasia Hypersensitivity Significant drug interaction
 Other, please explain: _____

No clinical reason not to use methotrexate or leflunomide

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

Sarcoidosis

- Yes No Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?
- Yes No Has the patient experienced an inadequate response with corticosteroids or immunosuppressive therapy (e.g., azathioprine, methotrexate)?
 - Yes No Has the patient experienced an intolerance to corticosteroids and immunosuppressive therapy (e.g., azathioprine, methotrexate)?
 - Yes No Does the patient have a contraindication to corticosteroids and immunosuppressive therapy (e.g., azathioprine, methotrexate)?

Takayasu's arteritis

- Yes No Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?
- Yes No Has the patient been diagnosed with refractory Takayasu's arteritis?
- Yes No Has the patient experienced an inadequate response with corticosteroids or immunosuppressive therapy (e.g., methotrexate, azathioprine, mycophenolate mofetil)?
 - Yes No Has the patient experienced an intolerance to corticosteroids and immunosuppressive therapy (e.g., methotrexate, azathioprine, mycophenolate mofetil)?
 - Yes No Does the patient have a contraindication to corticosteroids and immunosuppressive therapy (e.g., methotrexate, azathioprine, mycophenolate mofetil)?

Ulcerative colitis

- Please indicate loading dose at weeks 0, 2 and 6: _____ Please indicate maintenance dose: _____ frequency: _____ weeks
- Yes No Has the patient been diagnosed with moderately to severely active ulcerative colitis (UC)?
 - Yes No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Xeljanz) indicated for moderately to severely active ulcerative colitis?
 - Yes No Has the patient been hospitalized for acute severe ulcerative colitis (e.g., continuous bleeding, severe toxic symptoms, including fever and anorexia)?
 - 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, hydrocortisone, methylprednisolone, [Medrol, Solu-Medrol], prednisone, cyclosporine [Sandimmune], mesalamine [e.g., Apriso, Asacol, Lialda, Pentasa, Canasa, Rowasa] balsalazide, or olsalazine), mercaptopurine [Purinethol], sulfasalazine, tacrolimus [Prograf]?
- Please select: Azathioprine (Azasan, Imuran) Corticosteroid (e.g., hydrocortisone [Cortifoam, Colocort, Solu-Cortef, Cortef], methylprednisolone [Medrol, Solu-Medrol], prednisone) Cyclosporine (Sandimmune) Mesalamine (e.g., Apriso, Asacol, Lialda, Pentas, Canasa, Rowasa) balsalazide, or olsalazine Mercaptopurine (Purinethol) Sulfasalazine Tacrolimus (Prograf)

Uveitis

- Yes No Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?
- Yes No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for the treatment of uveitis?
 - Yes No Has the patient experienced an inadequate response with corticosteroids or immunosuppressive therapy (e.g., methotrexate, azathioprine, mycophenolate mofetil)?
 - Yes No Has the patient experienced an intolerance to corticosteroids and immunosuppressive therapy (e.g., methotrexate, azathioprine, mycophenolate mofetil)?
 - Yes No Does the patient have a contraindication to corticosteroids and immunosuppressive therapy (e.g., methotrexate, azathioprine, mycophenolate mofetil)?

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

- Please indicate maintenance dose: _____ frequency: _____ weeks
- Yes No Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
 - Yes No Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?
 - Supported by the manufacturer's prescribing information
 - Yes No Is the requested dose and frequency supported by the manufacturer's prescribing information for the patient's diagnosis?
 - Supported by dosing guidelines found in the compendia or current literature
 - Yes No Is the supporting information attached?

For All Conditions (Exception Crohns and Rheumatoid arthritis)

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

Acute graft versus host disease

- Yes No Has the patient experienced an inadequate response to systemic corticosteroids?
 - Yes No Does the patient have an intolerance or contraindication to corticosteroids?

Ankylosing spondylitis and axial spondyloarthritis

- Please indicate which of the following the patient has experienced an improvement in from baseline:
- functional status total spinal pain inflammation (e.g., morning stiffness) none of the above

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

Crohn's disease

- Yes No Is this a request for a change in dosing regimen?
- Yes No For dosage requests above 5mg only: Does the prescriber recognize that a dose above 5 mg/kg is a high dose and the prescriber confirms that appropriate monitoring will be done?
- Yes No Does the patient require a dose above 5 mg per kg due to loss of response at the current dose?
- Yes No Does the prescribed dose exceed 10 mg per kg?
- Yes No Has the patient achieved or maintained remission?
 - Yes No Has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?
 - Please indicate which of the following the patient has experienced an improvement in from baseline:
 - abdominal pain or tenderness diarrhea body weight abdominal mass hematocrit
 - endoscopic appearance of the mucosa improvement on a disease activity scoring tool (e.g., Crohn's disease Activity Index [CDAI] score) none of the above

Hidradenitis suppurativa

- Please indicate which of the following the patient has experienced since starting treatment with the requested drug:
- reduction in abscess and inflammatory nodule count from baseline reduced formation of new sinus tracts and scarring
 - decrease in frequency of inflammatory lesions from baseline reduction in pain from baseline reduction in suppuration from baseline
 - improvement in frequency of relapses from baseline improvement in quality of life from baseline
 - improvement on a disease severity assessment tool from baseline none of the above

Immune checkpoint inhibitor toxicity

- Yes No Has the patient experienced an inadequate response to corticosteroids?
 - Yes No Has the patient experienced an intolerance to corticosteroids?
 - Yes No Does the patient have a contraindication to corticosteroids?
 - Yes No Does the patient have cardiac toxicity?
 - Yes No Does the patient have moderate or severe diarrhea or colitis?

Juvenile idiopathic arthritis

- Please indicate which of the following the patient has experienced an improvement in from baseline:
- number of joints with active arthritis (e.g., swelling, pain, limitation of motion) number of joints with limitation of movement
 - functional ability none of the above

Plaque psoriasis

- Yes No Has the patient experienced a reduction in body surface area (BSA) affected from baseline?
 - Yes No Has the patient experienced an improvement in signs and symptoms of the condition from baseline (e.g., itching, redness, flaking, scaling, burning, cracking, pain)?

Psoriatic arthritis

- Please indicate which of the following the patient has experienced an improvement in from baseline:
- number of swollen joints number of tender joints dactylitis enthesitis skin and/or nail involvement none of the above

Reactive arthritis

- Yes No Has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition (e.g., tender joint count, swollen joint count, or pain)?

Rheumatoid arthritis

- Yes No Is this a request for a change in dosing regimen?
- Yes No Does the patient require a dose above 3 mg per kg due to an incomplete response at the current dose?
- Yes No Does the prescribed dose exceed 10 mg per kg?
- Yes No Has the patient achieved or maintained positive clinical response since starting treatment with the requested drug?
 - Please indicate the percent of disease activity improvement from baseline in tender joint count, swollen joint count, pain, or disability: _____ %
- Yes No Does the patient require dosing more frequent than every 8 weeks due to an incomplete response at the current dosing frequency?

Ulcerative colitis:

- Yes No For dosage requests above 5mg only: Does the prescriber recognize that a dose above 5 mg/kg is a high dose and the prescriber confirms that appropriate monitoring will be done?
- Yes No Has the patient achieved or maintained remission?
 - Please indicate which of the following the patient experienced from baseline: stool frequency rectal bleeding
 - C-reactive protein (CRP) fecal calprotectin (FC) endoscopic appearance of the mucosa urgency of defecation
 - improvement on a disease activity scoring tool (e.g., Ulcerative Colitis Endoscopic Index of Severity [UCEIS], Mayo Score)
 - none of the above

Uveitis

- Please indicate which of the following the patient has experienced since starting treatment with the requested drug:
- reduced frequency of recurrence compared to baseline decreased reliance on topical corticosteroids
 - zero anterior chamber inflammation or reduction in anterior chamber inflammation compared to baseline none of the above

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.