Inflectra® (infliximab-dyyb) Injectable Medication Precertification Request

(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 #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ 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:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

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, Does the patient have latent or active tuberculosis TB? ☐ latent ☐ active ☐ unknown
If latent tuberculosis ☐ 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 tuberculosis (TB)? (e.g., persons with close contact to people with infectious TB disease; persons who have recently immigrated from areas of the world with high rates of TB [e.g., Africa, Asia, Eastern Europe, Latin America, Russia]; children less than 5 years of age who have a positive TB test; groups with high rates of TB transmission [e.g., homeless persons, injection drug users, persons with HIV infection], or persons who work or reside with people who are at an increased risk for active TB [e.g., hospitals, long-term care facilities, correctional facilities, homeless shelters])?

→ ☐ 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 tuberculosis (TB) test: ☐ positive ☐ negative ☐ unknown
If positive, Does the patient have latent or active tuberculosis (TB)? ☐ latent ☐ active ☐ unknown
If latent tuberculosis ☐ Yes ☐ No Has treatment for latent tuberculosis (TB) infection been initiated or completed?
→ Please select: ☐ treatment initiated ☐ treatment completed

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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?

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 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

Please indicate the preferred alternatives for Crohn's disease that have been ineffective, not tolerated, or are contraindicated:

☐ Humira ☐ Entyvio ☐ Remicade ☐ Stelara (intravenous formulation)

Continued on next page

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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?

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

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

☐ 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 (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?

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: _____

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

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

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 Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?

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

☐ 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)?

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 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 ☐ 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)?
→ 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 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 Has the patient been tested for the rheumatoid factor (RF) biomarker?
Please indicate the test result: ☐ positive ☐ negative ☐ not completed
☐ Yes ☐ No Has the patient been tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker?
Please indicate the test result: ☐ positive ☐ negative ☐ not completed
☐ Yes ☐ No Has the patient been tested for the C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR) biomarker(s)?
Please indicate the test result: ☐ positive ☐ negative ☐ not completed
☐ Yes ☐ No Has the patient been tested for the erythrocyte sedimentation rate (ESR) biomarker?
Please indicate the test result: ☐ positive ☐ negative ☐ not completed
☐ 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 20 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.

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 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 disease modifying 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 [e.g., budesonide [Entocort, Uceris], hydrocortisone [Cortifoam, Colocort, Solu-Cortef, Cortef], methylprednisolone [Medrol, Solu-Medrol], prednisone, cyclosporine [Sandimmune], mesalamine [e.g., Apriso, Asacol, Lialda, Pentasa, Canasa, Rowasa] balsalazide, or olsalazine], mercaptopurine Purinethol], sulfasalazine, tacrolimus [Prograf], metronidazole (Flagyl) or ciprofloxacin (Cipro) [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) balsalazide, or olsalazine ☐ 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)

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)?

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

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)?

→ 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?

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?

Continued on next page

Inflectra® (infliximab-dyyb) Injectable Medication Precertification Request

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

Aetna Precertification Notification
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

Patient First Name	Patient Last Name	Patient Phone	Patient DOB

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

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

Crohn's disease
☐ Yes ☐ No Is this a request for a change in dosing regimen?
☐ 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?

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 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.