



Remicade® (infliximab) Injectable Medication Precertification Request

Page 1 of 6

(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): <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: _____	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: Remicade (infliximab) 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

Continued on next page



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Page 2 of 6

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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 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

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)?

Continued on next page



Remicade® (infliximab) Injectable Medication Precertification Request

Page 3 of 6

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

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?

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)?

Continued on next page



Remicade® (infliximab) Injectable Medication Precertification Request

Page 4 of 6

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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 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 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

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)?

Continued on next page



Remicade® (infliximab) Injectable Medication Precertification Request

Page 5 of 6

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

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)

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)?

For All Conditions (Exception 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

Crohn's disease

- Yes No Has the patient achieved or maintained remission?
 - Yes No 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

Continued on next page



Remicade® (infliximab) Injectable Medication Precertification Request

Page 6 of 6

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

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 Has the patient achieved or maintained positive clinical response since starting treatment with the requested drug?
- Yes No Please indicate the percent of disease activity improvement from baseline in tender joint count, swollen joint count, pain, or disability: _____ %

Ulcerative colitis:

- Yes No Has the patient achieved or maintained remission?
- Yes No 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.