HIGHMARK WESTERN NEW YORK

Outpatient Medical Injectable Infliximab Authorization Request Form
Fax to 833-619-5745
(Medical Benefit Only)

Member Name: _____ DOB: _____

Member UMI: _____ ☐ Medicare ☐ Commercial

Address: _____

REQUESTING PHYSICIAN INFORMATION

Physician Name: _____ NPI: _____

Address: _____

Office Contact: _____ Phone Number: _____ Fax Number: _____

SITE OF CARE

Place of Administration Name: _____ NPI: _____

Address: _____

Place of Administration Type *(please select one)*

☐ Home Infusion ☐ Office – Professional ☐ Ambulatory Infusion Suite – Professional ☐ Outpatient Hospital

Is the site of care affiliated with a hospital or will the claim be billed as a facility claim? ☐ Yes ☐ No

Drug Dispensing Information *(please select one)*

☐ Supplied by a Specialty Pharmacy *(for Home Infusion, Office – Professional, or Ambulatory Infusion Suite – Professional)*
Name: _____ NPI: _____

☐ Buy & Bill *(for Office – Professional or Outpatient Hospital administration)*

DRUG INFORMATION *(please select one)*

PREFERRED for ALL indications

☐ **Avsola Q5121**

☐ **Inflectra Q5103**

**Medicare members currently established on a non-preferred therapy are not required to try a preferred option

NON-PREFERRED**:

☐ Remicade J1745 ☐ Renflexis Q5104

Has the member experienced a documented drug therapy failure or intolerance to the preferred products?

Avsola: ☐ **Yes** ☐ **No**

Inflectra: ☐ **Yes** ☐ **No**

A non-preferred product will be considered when the member has a documented drug therapy failure after an adequate therapeutic trial, or intolerance, or contraindication to **BOTH preferred products

****Please verify member's eligibility and benefits through the health plan****

Fax this completed form to Highmark at 1-833-619-5745

DRUG INFORMATION *(continued)*

Requested Drug Name: _____Strength or Dose: _____

Directions: _____Quantity (# of doses/visits): _____

CLINICAL INFORMATION

Diagnosis code (ICD10): _____Member weight: _____

Diagnosis Description (check one)

☐ Ankylosing Spondylitis (AS)	☐ Non-infectious Uveitis	☐ Juvenile Rheumatoid Arthritis (JRA/JIA)
☐ Crohn's Disease (CD)	☐ Ulcerative Colitis (UC)	☐ Psoriatic Arthritis (PsA)
☐ Rheumatoid Arthritis (RA) *** Is Infliximab being used in combination with Methotrexate? ☐ YES ☐ NO* *** If NO, please explain: _____*		
☐ Other		

Does the member have moderate to severe disease? _____

List all previous therapies tried and failed _____

_____

☐ **New Start**	☐ **Continuation of Therapy** Date of last infusion: _____ Has the member demonstrated disease stability or a beneficial response to therapy? ☐ YES ☐ NO

Please attach all pertinent clinical information

Attached: ☐ YES ☐ NO

****Please verify member's eligibility and benefits through the health plan****

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