Infliximab (Medical Policy II-97)
Commercial and Medicaid Pre-authorization (PA) Request Form

BlueCross BlueShield Minnesota

Please refer to medical policy criteria on providers.bluecrossmn.com for clinical review criteria prior to submission.

Effective May 1, 2019, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) providers are required to use the Availity® Provider Portal to submit preservice prior authorization requests. **Faxes and phone calls for these requests will no longer be accepted by Blue Cross.** Please complete the clinical sections on this form and attach it to your request at **Availity.com** to ensure a timely review.

Providers outside of Minnesota without electronic access can fax this form, along with clinical records to support the request, to (651) 662-2810.

Patient Information

Will waiting the standard review time seriously jeopardize the life or health of the member or the member's ability to regain maximum function? ☐ **Yes** ☐ **No**

Member ID: _____ _____ Group number: _____

Member name: _____ Date of birth: ___ /___ /_____

Member address: _____

Member city/state/ZIP: _____

Member phone: _____

Servicing Provider Information

Contact person: _____ Phone: _____

Servicing provider name: _____

Servicing provider ID/NPI number: _____

Servicing provider address: _____

City/state/ZIP: _____

Servicing provider phone: _____ Servicing provider fax _____

Inpatient/outpatient facility name: _____ Facility ID:_____

Ordering Provider Information

Ordering provider name: _____

Ordering provider ID/NPI number: _____

Ordering provider address: _____

City/state/ZIP: _____

Ordering provider phone: _____ Ordering provider fax _____

Services/Procedures/Items Requested

HCPC/CPT Code(s)	HCPC/CPT Code(s) Description	ICD-10 Diagnosis Code(s)	Start Date mm/dd/yy	End Date mm/dd/yy

Place of Service: ☐ Home ☐ Office ☐ Infusion Center ☐ Other: _____

Healthcare professional to administer? ☐ No ☐ Yes → If yes, Buy and Bill? ☐ Yes ☐ No

Please attach all relevant clinical documentation that supports information selected in the form.

Member ID: _____ _____

Patient History (Initial and Renewal Requests) Patient History

Is the patient currently being treated with infliximab? ☐ Yes ☐ No

Is the patient currently being treated with another biologic immunomodulator? ☐ Yes ☐ No

If yes, will the other biologic immunomodulator(s) be discontinued before starting infliximab treatment? ☐ Yes ☐ No

Has the patient been treated with another biologic immunomodulator with FDA approval for the same indication? ☐ Yes ☐ No

If yes, please specify the agent(s): _____

Does the patient have a history of hypersensitivity reactions to infliximab? ☐ Yes ☐ No

Does the patient have a history of moderate-to-severe heart failure? ☐ Yes ☐ No

Has the patient been screened for hepatitis B infection? ☐ Yes ☐ No

If yes, did the patient test positive for hepatitis B? ☐ Yes ☐ No

If yes, is the patient established on appropriate therapy to treat hepatitis B? ☐ Yes ☐ No

Has the patient been screened for tuberculosis (TB)? ☐ Yes ☐ No

If yes, did the patient test positive for TB? ☐ Yes ☐ No

If yes, is the patient established on appropriate therapy to treat TB? ☐ Yes ☐ No

Requested Dose / Frequency

Note: Requested Dose/Frequency AND Initial OR Renewal Sections must be completed.

What is the patient's current weight? _____ ☐ KG ☐ LB

Please select the indication(s) and requested dose/frequency

Indication(s)	Initial Dose Requested	Maintenance Dose Requested
☐ **Ankylosing Spondylitis**	☐ 5 mg/kg, at weeks 0, 2, and 6	☐ 5 mg/kg every 6 weeks
☐ **Crohn's Disease** – Adult	☐ 5 mg/kg, at weeks 0, 2, and 6	☐ 5-10 mg/kg every 8 weeks
☐ **Crohn's Disease** – Pediatric (6-17 y/o)	☐ 5 mg/kg, at weeks 0, 2, and 6	☐ 5 mg/kg every 8 weeks
☐ **Juvenile Idiopathic Arthritis**	☐ 3-6 mg/kg, at weeks 0, 2, and 6	☐ 3-6 mg/kg every 8 weeks
☐ **Management of Immune Checkpoint Inhibitor Related Toxicity**	☐ 5 mg/kg, at weeks 0 and 2	☐ NA
☐ **Psoriasis**	☐ 5 mg/kg, at weeks 0, 2, and 6	☐ 5 mg/kg every 8 weeks
☐ **Psoriatic Arthritis**	☐ 5 mg/kg, at weeks 0, 2, and 6	☐ 5 mg/kg every 8 weeks
☐ **Rheumatoid Arthritis**	☐ 3 mg/kg, at weeks 0, 2, and 6	☐ 3-10 mg/kg every 4-8 weeks
☐ **Ulcerative Colitis**	☐ 5 mg/kg, at weeks 0, 2, and 6	☐ 5 mg/kg every 8 weeks
☐ **Uveitis, Non-Infectious**	☐ 5 mg/kg, at weeks 0, 2, and 6	☐ 5 mg/kg every 6-8 weeks
☐ **Other*** (describe):	Dose: _____ Frequency: _____	Dose: _____ Frequency: _____

*Compared to dosing criteria in Medical Policy II-97, is the requested:

Dose higher than the maximum dose for the indication being treated? ☐ Yes** ☐ No

Dosing interval more frequent than the dosing interval for the indication being treated? ☐ Yes** ☐ No

****If yes, please attach clinical information to support the requested indication, dose, and/or frequency.**

Member ID: _____ _____

Site of Care

For commercial and Medicaid health plan members, please select at least ONE of the following criteria that was met*

- ☐ Age <18 years
- ☐ First dose OR <60 days from the first dose
- ☐ Reinitiating therapy after not being on therapy for ≥6 months
- ☐ Nearest non-hospital outpatient facility with infusion or injection capabilities is >30 miles from patient's home AND patient is not eligible for home infusion
- ☐ History of a severe adverse event with prior infusion or injection therapy (e.g., anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure);
- ☐ History of adverse events with prior infusion or injection therapy (e.g., hypersensitivity or allergic reactions), which have not been successfully managed through standard premedications or infusion rate adjustments
- ☐ Comorbidity or medical condition that increases the risk of an adverse event, including but not limited to the following:
  - Cardiopulmonary conditions
  - Inability to safely tolerate intravenous volume loads, including unstable renal function
  - Difficult or unstable vascular access
- ☐ Physical or cognitive impairment such that infusion or injection in a non-hospital outpatient setting would present an unnecessary health risk; or
- ☐ Concurrent treatment with medications that require a higher level of monitoring (e.g., intravenous cytotoxic chemotherapy, blood products).

* If Infliximab is administered in a hospital outpatient facility, a clear explanation for the medical necessity of the site of care MUST be submitted, including documentation for one or more of the site of care criteria provided in the table above. When the above criteria for the hospital outpatient setting are not met, a non-hospital outpatient setting (i.e., physician's office, infusion center, or home) should be

Please select the indication(s) below and answer the corresponding questions. If applicable, please attach supporting documentation for drug intolerance, contraindication, or hypersensitivity

Initial Request

☐ **Ankylosing Spondylitis**

Does the patient have active disease? ☐ Yes ☐ No

Has the patient tried TWO conventional agents to treat the diagnosis? (check all that apply) ☐ Yes ☐ No

☐ NSAIDS (ibuprofen, ketoprofen, celecoxib) ☐ Other: _____

Does the patient have a documented intolerance, FDA-labeled contraindication, or hypersensitivity to any NSAIDS? ☐ Yes ☐ No

If yes, please specify drug and dose: _____

☐ **Crohn's Disease**

Does the patient have moderately to severely active disease? ☐ Yes ☐ No

Does the patient have perianal fissuring or chronic fistulizing Crohn's disease? ☐ Yes ☐ No

Has the patient tried any conventional agents to treat the diagnosis? (check all that apply) ☐ Yes ☐ No

☐ Aminosalicylates ☐ Ciprofloxacin ☐ Corticosteroids (including budesonide EC capsules)

☐ Azathioprine ☐ Methotrexate

☐ Metronidazole ☐ 6-Mercaptopurine ☐ Other: _____

Does the patient have a documented intolerance, FDA-labeled contraindication, or hypersensitivity to the conventional agents? ☐ Yes ☐ No

If yes, please specify: _____

Member ID: _____ _____

Initial Request (continued)

☐ **Immune Checkpoint Inhibitor Related Toxicity**

Does the patient have one or more of the following toxicities related to immunotherapy ? (check all that apply) ☐ Yes ☐ No

☐ Moderate (grade 2) to severe (grade 3-4) diarrhea or colitis
☐ Severe (grade 3-4) pneumonitis refractory to methylprednisone after 48 hours of therapy
☐ Severe (grade 3) or life-threatening (grade 4) elevated serum creatine / acute kidney injury that is refractory to at least 1 week of therapy with corticosteroids
☐ Uveitis (grade 3-4) that is refractory to high-dose systematic corticosteroids
☐ Suspected myocarditis if no improvement within 24 hours of starting pulse-dose methylprednisolone
☐ Severe inflammatory arthritis as additional disease-modifying therapy refractory to high-dose corticosteroids after 7 days of treatment or if unable to taper corticosteroids by day 14
☐ Moderate, severe, or life-threatening steroid-refractory myalgias or myositis

Is the patient currently receiving therapy with an immune checkpoint inhibitor? ☐ Yes ☐ No

☐ **Juvenile Idiopathic Arthritis**

Does the patient have moderately to severely active disease? ☐ Yes ☐ No
Has the patient tried any conventional agents to treat the diagnosis? (check all that apply) ☐ Yes ☐ No
☐ Hydroxychloroquine ☐ Methotrexate ☐ Sulfasalazine
☐ Leflunomide ☐ Minocycline ☐ Other: _____
Does the patient have a documented intolerance, FDA-labeled contraindication, or hypersensitivity to the conventional agents? ☐ Yes ☐ No
If yes, please specify: _____

☐ **Plaque Psoriasis**

Does the patient have moderate disease? ☐ Yes ☐ No
Does the patient have severe disease? ☐ Yes ☐ No
Does the patient have moderate to severe disease and concomitant psoriatic arthritis? ☐ Yes ☐ No
Has the patient tried any conventional agents to treat the diagnosis? (check all that apply) ☐ Yes ☐ No
☐ Acitretin ☐ Calcipotriene ☐ Methotrexate ☐ PUVA (phototherapy)
☐ Anthralin ☐ Coal tar ☐ Methoxsalen ☐ Tacrolimus ☐ Topical corticosteroids
☐ Calcitriol ☐ Cyclosporine ☐ Pimecrolimus ☐ Tazarotene ☐ Other: _____
Does the patient have a documented intolerance, FDA-labeled contraindication, or hypersensitivity to the conventional agents? ☐ Yes ☐ No
If yes, please specify: _____

☐ **Psoriatic Arthritis**

Does the patient have active disease? ☐ Yes ☐ No
Does the patient have severe active disease? ☐ Yes ☐ No
Does the patient have active disease and concomitant severe psoriasis? ☐ Yes ☐ No
Has the patient tried any conventional agents to treat the diagnosis? (check all that apply) ☐ Yes ☐ No
☐ Hydroxychloroquine ☐ Methotrexate ☐ Sulfasalazine
☐ Leflunomide ☐ Minocycline ☐ Other: _____
If yes, please specify: _____
Does the patient have a documented intolerance, FDA-labeled contraindication, or hypersensitivity to any of the conventional agents? ☐ Yes ☐ No
If yes, please specify: _____

Member ID: _____ _____

Initial Request (continued)

☐ **Rheumatoid Arthritis**
Does the patient have moderately to severely active disease? ☐ Yes ☐ No
Has the patient tried any conventional agents to treat the diagnosis? (check all that apply) ☐ Yes ☐ No
☐ Hydroxychloroquine ☐ Methotrexate ☐ Sulfasalazine
☐ Leflunomide ☐ Minocycline ☐ Other: _____
Does the patient have a documented intolerance, FDA-labeled contraindication, or hypersensitivity to the conventional agents? ☐ Yes ☐ No
If yes, please specify: _____

☐ **Ulcerative Colitis**
Does the patient have moderately to severely active disease? ☐ Yes ☐ No
Has the patient tried any conventional agents to treat the diagnosis? (check all that apply) ☐ Yes ☐ No
☐ Aminosalicylates ☐ Ciprofloxacin ☐ Corticosteroids (including budesonide EC capsules)
☐ Azathioprine ☐ Methotrexate
☐ Metronidazole ☐ 6-Mercaptopurine ☐ Other: _____
Does the patient have a documented intolerance, FDA-labeled contraindication, or hypersensitivity the conventional agents? ☐ Yes ☐ No
If yes, please specify: _____

☐ **Uveitis, Non-infectious**
Does the patient have chronic, recurrent, treatment-refractory, or vision-threatening disease? ☐ Yes ☐ No
Has the patient tried TWO conventional agents from different drug classes to treat the diagnosis? ☐ Yes ☐ No
(check all that apply)
☐ Azathioprine ☐ Methotrexate ☐ NSAIDS (ibuprofen, ketoprofen, celecoxib)
☐ Cyclosporine ☐ Sulfasalazine ☐ Ophthalmic Corticosteroids (prednisone, rimexolone)
☐ Ophthalmic Cycloplegic Agents (atropine, homatropine, scopolamine, cyclopentolate)
☐ Other: _____
Does the patient have a documented intolerance, FDA-labeled contraindication, or hypersensitivity to two of the conventional agents from different drug classes? ☐ Yes ☐ No
If yes, please specify drug and dose: _____

☐ **Other*** (please specify below)

Renewal Request

Note: Requested Dose/Frequency **AND** Patient History Sections must also be completed.

Has the patient been previously approved for infliximab through Blue Cross and Blue Shield of Minnesota's initial review process? ☐ Yes ☐ No

Has the patient shown positive clinical response (i.e., slowing of disease progression or decrease in symptom severity, and/or frequency) while on infliximab therapy? ☐ Yes ☐ No

Please attach all relevant clinical documentation that supports information selected in the form.

Description / Additional Information:

Member ID: _____ _____

Total Pages _____