Prescriber Criteria Form

Infliximab 2026 PA Fax 187-A v2 010126.docx
Remicade (infliximab), Avsola (infliximab-axxq), Inflectra (infliximab-dyyb)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Infliximab.

Drug Name (select from list of drugs shown):

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Has the patient previously received the requested medication for one of the following conditions: A) Crohn's disease, B) ulcerative colitis, C) rheumatoid arthritis, D) ankylosing spondylitis, E) psoriatic arthritis, F) plaque psoriasis, G) Behcet's disease, H) hidradenitis suppurativa, I) sarcoidosis, J) Takayasu's arteritis, K) uveitis? [If yes, then skip to question 19.]	Yes	No
2	Does the patient have a diagnosis of moderately to severely active Crohn's disease? [If yes, then skip to question 19.]	Yes	No
3	Does the patient have a diagnosis of moderately to severely active ulcerative colitis? [If yes, then skip to question 19.]	Yes	No
4	Does the patient have a diagnosis of moderately to severely active rheumatoid arthritis? [If no, then skip to question 7.]	Yes	No
5	Does the patient meet ONE of the following criteria: A) the requested medication will be used in combination with methotrexate, B) patient has a contraindication or intolerance to methotrexate? [If no, then no further questions.]	Yes	No
6	Does the patient meet ANY of the following: A) patient has experienced an inadequate treatment response, intolerance or contraindication to methotrexate, B) patient has experienced an inadequate treatment response or intolerance to a prior biologic disease-	Yes	No

	modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD? [If yes, then skip to question 19.] [If no, then no further questions.]		
7	Does the patient have a diagnosis of active ankylosing spondylitis? [If no, then skip to question 9.]	Yes	No
8	Has the patient experienced an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR does the patient have a contraindication that would prohibit a trial of NSAIDs? [If yes, then skip to question 19.] [If no, then no further questions.]	Yes	No
9	Does the patient have a diagnosis of active psoriatic arthritis? [If yes, then skip to question 19.]	Yes	No
10	Does the patient have a diagnosis of moderate to severe plaque psoriasis? [If no, then skip to question 14.]	Yes	No
11	Does the patient meet one of the following criteria: A) crucial body areas [e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas] are affected, B) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e. at least 10 percent of the body surface area [BSA] is affected)? [If yes, then skip to question 19.]	Yes	No
12	Is at least 3 percent of body surface area (BSA) affected by plaque psoriasis at the time of diagnosis? [If no, then no further questions.]	Yes	No
13	Does the patient meet either of the following criteria: A) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., ultraviolet B [UVB], psoralen plus ultraviolet A [PUVA]) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, B) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated? [If yes, then skip to question 19.] [If no, then no further questions.]	Yes	No
14	Does the patient have a diagnosis of hidradenitis suppurativa? [If no, then skip to question 16.]	Yes	No
15	Does the patient have severe, refractory disease? [If yes, then skip to question 19.] [If no, then no further questions.]	Yes	No
16	Does the patient have a diagnosis of uveitis? [If no, then skip to question 18.]	Yes	No
17	Has the patient experienced an inadequate treatment response or intolerance or does the patient have a contraindication to a trial of immunosuppressive therapy for uveitis?	Yes	No

	[If yes, then skip to question 19.] [If no, then no further questions.]		
18	Does the patient have a diagnosis of ONE of the following conditions: A) Behcet's syndrome, B) sarcoidosis, C) Takayasu's arteritis? [If no, then no further questions.]	Yes	No
19	Has the patient experienced an intolerable adverse event to Renflexis and that adverse event was NOT attributed to the active ingredient as described in the prescribing information?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____