PriorityHealth

Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**
This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Inflectra™ (infliximab-dyyb)

Member

Last Name: ______________________ First Name: ______________________
ID #: ______________________ DOB: ____________ Gender: ____________
Primary Care Physician: ______________________

Requesting Provider: ______________________ Prov. Phone: ____________ Prov. Fax: ____________
Provider Address: ______________________
Provider NPI: ______________________ Contact Name: ______________________

Provider Signature: ______________________ Date: ____________

Drug information

☐ Inflectra 100 mg

Dose:__________ **Dose Frequency**:______________________
Start date: ______________________
Date of last dose: ______________________
Date of next dose: ______________________

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

1. Must be used for a medically-accepted indication*
2. Must have a negative TB test within the last 12 months (testing must be done yearly)
3. For certain diagnoses, additional criteria is required:

Diagnosis	Additional criteria required
Ankylosing spondylitis, plaque psoriasis, psoriatic arthritis	Trial and failure with either Enbrel or Humira
Crohn's disease	Documented therapeutic trial and clinical failure with Humira
Rheumatoid arthritis	Documented therapeutic trial of at least one DMARD *AND* either Enbrel or Humira
Ulcerative colitis	Therapeutic trial of at least one of the following: aminosalicylates or steroids

Additional information

Note: Coverage is provided for 1 year per approved authorization

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 01/2018
Last reviewed 01/2018

Medically accepted indication*

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

New request
Priority Health Precertification Documentation

A. What is the date and result of the patient's last TB test?

Date: ______________________ ☐ Negative
☐ Positive

B. What condition is this drug being requested for?

The patient's condition is:	Additional information needed based on the patient's condition
☐ Ankylosing spondylitis ☐ Psoriatic arthritis ☐ Plaque psoriasis	**Which of the following drugs has the patient tried and failed?** ☐ Enbrel ☐ Humira ☐ None of the above
☐ Crohn's disease	**Has the patient had a therapeutic trial and clinical failure with Humira?** ☐ Yes ☐ No
☐ Rheumatoid arthritis	**Which of the following drugs has the patient tried?** ☐ non-biologic DMARD – drug name: ________________________________ ☐ Enbrel ☐ Humira
☐ Ulcerative colitis	**Which of the following drugs has the patient tried?** ☐ Aminosalicylates ☐ Corticosteroids ☐ None of the above

Priority Health Medicare exception request

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Inflectra likely be the most effective option for this patient?
☐ No
☐ Yes, because:____

PriorityHealth

If the patient is currently using Inflectra, would changing the patient's current regimen likely result in adverse effects for the patient?

☐ No
☐ Yes, because:____

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 01/2018
Last reviewed 01/2018