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.

Renflexis™ (infliximab-abda)

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

☐ New request ☐ Continuation request

☒ Renflexis 100 mg powder for injection

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

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.

For this drug to be covered, the patient must meet the following criteria:

1. Use is for a medically-accepted indication* not otherwise excluded from Part D
   - For ulcerative colitis: must have a therapeutic trial of at least one of the following: aminosalicylates or steroids
   - For rheumatoid arthritis: must have a documented therapeutic trial of at least one DMARD and either Enbrel or Humira
   - For Crohn's disease: must have a documented therapeutic trial and clinical failure with Humira
   - For psoriatic arthritis, ankylosing spondylitis, plaque psoriasis: must have a trial and failure with Humira or Enbrel

2. Must have a negative TB test (must be done yearly)

Additional information

Note: When criteria are met, Renflexis will be approved for 12 months.

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

Updated 03/2018
Last reviewed 03/2018

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)

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	**Has the patient tried and failed one of the following?** ☐ Enbrel ☐ Humira ☐ None of the above. ***Rationale for use:*** _____
☐ Crohn's disease	**Has the patient had a documented therapeutic trial and clinical failure with Humira?** ☐ Yes ☐ No. ***Rationale for use:*** _____
☐ Rheumatoid arthritis	**Has the patient had a documented therapeutic trial with the following?** ☐ DMARD ☐ methotrexate ☐ leflunomide ☐ sulfasalazine ☐ hydroxychloroquine ☐ Other – drug name: _____ ☐ Enbrel ☐ Humira ☐ None of the above. ***Rationale for use:*** _____
☐ Ulcerative colitis	**Has the patient had a therapeutic trial with one of the following?** ☐ Aminosalicylates ☐ balsalazide ☐ Apriso ☐ Asacol HD ☐ Delzicol ☐ Lialda ☐ Pentasa ☐ Other – drug name: _____ ☐ Corticosteroids ☐ None of the above. ***Rationale for use:*** _____

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Updated 03/2018
Last reviewed 03/2018

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 Renflexis likely be the most effective option for this patient?
☐ No
☐ Yes, because:_____

_____

_____

If the patient is currently using Renflexis, would changing the patient's current regimen likely result in adverse effects for the patient?
☐ No
☐ Yes, because:_____

_____

_____

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Updated 03/2018
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