Remicade and biosimilars

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Drug Information:

Strength/Measure _____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
Directions(sig) _____ *Route of administration* _____
Dosing frequency _____

What is the ICD-10 code? _____

Exception Criteria Questions:

A. What product is being requested?
- ❑ Remicade
- ❑ non-branded infliximab NDC 57894016001
- ❑ Avsola, *Skip to Site of Service Questions*
- ❑ Inflectra, *Skip to Site of Service Questions*
- ❑ Renflexis,

B. The preferred products for your patient's health plan are Avsola and Inflectra.

Can the patient's treatment be switched to a preferred product?

Send completed form to: Priority Partners Fax: 1-866-212-4756

 JHHC Remicade and biosimilars MR SOC SGM 4940-D, 2182-A – 02/2024.

❑ Yes – Avsola, *Skip to Site of Service Questions*
❑ Yes – Inflectra, *Skip to Site of Service Questions*
❑ No

C. Does the patient have a documented intolerable adverse event to both of the preferred products (Avsola and Inflectra)? ***ACTION REQUIRED: If 'Yes', attach supporting chart note(s)***.
❑ Yes ❑ No *If No, Skip to Site of Service Questions*

D. Was the documented intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference product and biosimilar products)? ***ACTION REQUIRED: If 'No', attach supporting chart note(s).*** ❑ Yes ❑ No

Site of Service Questions:

A. Indicate the site of service requested:
❑ Ambulatory Surgical (POS Code 24), *Skip to Clinical Criteria Questions*
❑ Home (POS Code 12), *Skip to Clinical Criteria Questions*
❑ Off Campus Outpatient Hospital (POS Code 19*)*
❑ On Campus Outpatient Hospital (POS Code 22)
❑ Office (POS Code 11), *Skip to Clinical Criteria Questions*

B. Is the patient less than 18 years of age?
❑ Yes, *skip to Clinical Criteria Questions*
❑ No

C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre- medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED:***
If 'Yes', please attach supporting clinical documentation. ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

D. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. Has the patient's home been deemed not eligible or appropriate for home infusion services by a home infusion provider? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

H. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?
ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation. ❑ Yes ❑ No

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Clinical Criteria Questions:

What product is being requested? ❑ Remicade ❑ Avsola ❑ Inflectra ❑ Renflexis ❑ Zymfentra

1. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Otezla, Xeljanz) for the same indication?
❒ Yes, *Continue to 2*
❒ No, *Continue to 2*

2. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis (TB)?
❒ Yes, *Continue to 6*
❒ No, *Continue to 3*

3. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [PPD], interferon-release assay [IGRA], chest x-ray) within 6 months of initiating therapy?
❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. What were the results of the tuberculosis (TB) test?
❒ Positive for TB, *Continue to 5*
❒ Negative for TB, *Continue to 6*
❒ Unknown, *No further questions*

5. Which of the following applies to the patient?
❒ Patient has latent TB and treatment for latent TB has been initiated, *Continue to 6*
❒ Patient has latent TB and treatment for latent TB has been completed, *Continue to 6*
❒ Patient has latent TB and treatment for latent TB has not been initiated, *Continue to 6*
❒ Patient has active TB, *Continue to 6*

6. What is the diagnosis?
❒ Crohn's disease, *Continue to 8*
❒ Ulcerative colitis, *Continue to 16*
❒ Rheumatoid arthritis, *Continue to 24*
❒ Ankylosing spondylitis, *Continue to 43*
❒ Non-radiographic axial spondyloarthritis, *Continue to 43*
❒ Psoriatic arthritis, *Continue to 53*
❒ Psoriatic arthritis WITH co-existent plaque psoriasis, *Continue to 7*
❒ Plaque psoriasis, *Continue to 69*
❒ Behcet's disease, *Continue to 85*
❒ Hidradenitis suppurativa, *Continue to 91*
❒ Pyoderma gangrenosum, *Continue to 101*
❒ Sarcoidosis, *Continue to 108*

❒ Takayasu's arteritis, *Continue to 114*

❒ Uveitis, *Continue to 121*

❒ Reactive arthritis, *Continue to 129*

❒ Immune checkpoint inhibitor-related toxicity, *Continue to 140*

❒ Immune checkpoint inhibitor-related inflammatory arthritis, *Continue to 144*

❒ Acute graft versus host disease, *Continue to 153*

❒ Other, please specify. _____, *No further questions*

7. What is the primary diagnosis being treated?

❒ Psoriatic arthritis, *Continue to 53*

❒ Plaque psoriasis, *Continue to 69*

8. Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Is the patient 6 years of age or older?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Is the requested drug being prescribed by or in consultation with a gastroenterologist?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 12*
❒ No, *Continue to 157*

12. Has the patient achieved or maintained remission? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of remission.
❒ Yes, *Continue to 157*
❒ No, *Continue to 13*

13. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 14*
❒ No, *Continue to 15*

14. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED***: Please attach chart notes or medical record documentation supporting positive clinical response to therapy.

❒ Abdominal pain or tenderness ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*

❒ Diarrhea ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*

❒ Body weight ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*

❒ Abdominal mass ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*

❒ Hematocrit ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*

❒ Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*

❒ Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index [CDAI] score) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*

❒ None of the above, *Continue to 15*

15. Is this request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose?
❒ Yes, *Continue to 157*
❒ No, *Continue to 157*

16. Has the patient been diagnosed with moderately to severely active ulcerative colitis (UC)?
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Is the patient 6 years of age or older?
❒ Yes, *Continue to 18*
❒ No, *Continue to 18*

18. Is the requested drug being prescribed by or in consultation with a gastroenterologist?
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

19. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 20*
❒ No, *Continue to 157*

20. Has the patient achieved or maintained remission? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of remission.
❒ Yes, *Continue to 157*
❒ No, *Continue to 21*

21. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 22*
❒ No, *Continue to 23*

22. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED***: Please attach chart notes or medical record documentation supporting positive clinical response to therapy.

❒ Stool frequency ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*

❒ Rectal bleeding ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*

❒ Urgency of defecation ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*

❒ C-reactive protein (CRP) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*

❒ Fecal calprotectin (FC) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*

❒ Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*

❒ Improvement on a disease activity scoring tool (e.g., Ulcerative Colitis Endoscopic Index of Severity [UCEIS], Mayo Score) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*

❒ None of the above, *Continue to 23*

23. Is this request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose?
❒ Yes, *Continue to 157*
❒ No, *Continue to 157*

24. Has the patient been diagnosed with moderately to severely active rheumatoid arthritis (RA)?
❒ Yes, *Continue to 25*
❒ No, *Continue to 25*

25. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 26*
❒ No, *Continue to 26*

26. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to 27*
❒ No, *Continue to 27*

27. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 28*
❒ No, *Continue to 32*

28. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 32*

❒ No, *Continue to 29*

❒ Unknown, *Continue to 32*

29. Has the patient achieved or maintained a positive clinical response since starting treatment with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 30*
❒ No, *Continue to 31*

30. Has the patient experienced substantial disease activity improvement (e.g., at least 20% from baseline) in tender joint count, swollen joint count, pain, or disability? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation supporting positive clinical response and substantial disease activity improvement. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 157*
❒ No, *Continue to 31*

31. Is this a request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose or frequency?
❒ Yes, *Continue to 157*
❒ No, *Continue to 157*

32. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) indicated for the treatment of moderately to severely active rheumatoid arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.
❒ Yes, *Continue to 33*
❒ No, *Continue to 35*

33. Is the requested medication being prescribed in combination with methotrexate or leflunomide?
❒ Yes, *Continue to 157*
❒ No, *Continue to 34*

34. Please indicate a clinical reason for the patient to not use methotrexate or leflunomide.
❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 157*

❒ Drug interaction, *Continue to 157*

❒ Risk of treatment-related toxicity, *Continue to 157*

❒ Pregnancy or currently planning pregnancy, *Continue to 157*

❒ Breastfeeding, *Continue to 157*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 157*

❒ Hypersensitivity, *Continue to 157*

❒ History of intolerance or adverse event, *Continue to 157*

❒ Other, please specify. _____, *Continue to 157*

❒ No clinical reason not to use methotrexate or leflunomide, *Continue to 157*

35. Does the patient meet either of the following: a) the patient was tested for the rheumatoid factor (RF) biomarker and the RF biomarker test was positive, or b) the patient was tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker and the anti-CCP biomarker test was positive? ***ACTION REQUIRED***: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing.
❒ Yes, *Continue to 37*
❒ No, *Continue to 36*

36. Has the patient been tested for all of the following biomarkers: a) rheumatoid factor (RF), b) anti-cyclic citrullinated peptide (anti-CCP), and c) C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR)? ***ACTION REQUIRED***: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing.
❒ Yes, *Continue to 37*
❒ No, *Continue to 37*

37. Is the requested medication being prescribed in combination with methotrexate or leflunomide?
❒ Yes, *Continue to 39*
❒ No, *Continue to 38*

38. Please indicate a clinical reason for the patient to not use methotrexate or leflunomide.

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 39*

❒ Drug interaction, *Continue to 39*

❒ Risk of treatment-related toxicity, *Continue to 39*

❒ Pregnancy or currently planning pregnancy, *Continue to 39*

❒ Breastfeeding, *Continue to 39*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 39*

❒ Hypersensitivity, *Continue to 39*

❒ History of intolerance or adverse event, *Continue to 39*

❒ Other, please specify. _____, *Continue to 39*

❒ No clinical reason not to use methotrexate or leflunomide, *Continue to 39*

39. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate at a dose greater than or equal to 15 mg per week? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 157*
❒ No, *Continue to 40*

40. Has the patient experienced an intolerance to methotrexate? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 157*
❒ No, *Continue to 41*

41. Does the patient have a contraindication to methotrexate? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 42*
❒ No, *Continue to 42*

42. Please indicate the contraindication to methotrexate.
❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 157*

❒ Drug interaction, *Continue to 157*

❒ Risk of treatment-related toxicity, *Continue to 157*

❒ Pregnancy or currently planning pregnancy, *Continue to 157*

❒ Breastfeeding, *Continue to 157*

❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 157*

❒ Hypersensitivity, *Continue to 157*

❒ History of intolerance or adverse event, *Continue to 157*

❒ Other, please specify _____, *Continue to 157*

43. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 44*
❒ No, *Continue to 44*

44. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to 45*
❒ No, *Continue to 45*

45. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 46*
❒ No, *Continue to 50*

46. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 50*

❒ No, *Continue to 47*

❒ Unknown, *Continue to 50*

47. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 48*
❒ No, *Continue to 49*

48. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED***: Please attach chart notes or medical record documentation supporting positive clinical response.

❒ Functional status ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*

❒ Total spinal pain ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*
❒ Inflammation (e.g., morning stiffness) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*

❒ None of the above, *Continue to 49*

49. Is this request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose?

❒ Yes, *Continue to 157*
❒ No, *Continue to 157*

50. Has the patient been diagnosed with active ankylosing spondylitis (AS) or active non-radiographic axial spondyloarthritis (nr-axSpA)?

❒ Yes - Active ankylosing spondylitis, *Continue to 51*

❒ Yes - Active non-radiographic axial spondyloarthritis, *Continue to 51*

❒ No, *Continue to 51*

51. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) indicated for the treatment of active ankylosing spondylitis or active non-radiographic axial spondyloarthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.
❒ Yes, *Continue to 157*
❒ No, *Continue to 52*

52. Has the patient experienced an inadequate response with at least TWO non-steroidal anti-inflammatory drugs (NSAIDs), or has an intolerance or contraindication to at least two NSAIDs? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 157*
❒ No, *Continue to 157*

53. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 54*
❒ No, *Continue to 54*

54. Is the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist?
❒ Yes, *Continue to 55*
❒ No, *Continue to 55*

55. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 56*
❒ No, *Continue to 60*

56. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 60*

❒ No, *Continue to 57*

❒ Unknown, *Continue to 60*

57. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 58*
❒ No, *Continue to 59*

58. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED***: Please attach chart notes or medical record documentation supporting positive clinical response.

❒ Number of swollen joints ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*

❒ Number of tender joints ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*

❒ Dactylitis ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*

❒ Enthesitis ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*

❒ Axial disease ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*

❒ Skin and/or nail involvement ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*

❒ None of the above, *Continue to 59*

59. Is this request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose?
❒ Yes, *Continue to 157*
❒ No, *Continue to 157*

60. Has the patient been diagnosed with active psoriatic arthritis (PsA)?
❒ Yes, *Continue to 61*
❒ No, *Continue to 61*

61. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Otezla) indicated for active psoriatic arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.
❒ Yes, *Continue to 157*
❒ No, *Continue to 62*

62. What is the patient's disease severity?

❒ Mild to moderate, *Continue to 63*

❒ Severe, *Continue to 157*

63. Does the patient have enthesitis or predominantly axial disease?
❒ Yes, *Continue to 157*
❒ No, *Continue to 64*

64. Has the patient had an inadequate response to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine) administered at an adequate dose and duration? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 157*
❒ No, *Continue to 65*

65. Has the patient had an intolerance to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 157*
❒ No, *Continue to 66*

66. Does the patient have a contraindication to methotrexate or leflunomide? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 67*
❒ No, *Continue to 68*

67. Please indicate the contraindication to methotrexate or leflunomide.
❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 157*

❒ Drug interaction, *Continue to 157*

❒ Risk of treatment-related toxicity, *Continue to 157*

❒ Pregnancy or currently planning pregnancy, *Continue to 157*

❒ Breastfeeding, *Continue to 157*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 157*

❒ Hypersensitivity, *Continue to 157*

❒ History of intolerance or adverse event, *Continue to 157*

❒ Other, please specify _____, *Continue to 157*

68. Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasalazine)? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 157*
❒ No, *Continue to 157*

69. Has the patient been diagnosed with moderate to severe plaque psoriasis?
❒ Yes, *Continue to 70*
❒ No, *Continue to 70*

70. Is the patient an adult (18 years of age or older)?

❒ Yes, *Continue to 71*
❒ No, *Continue to 71*

71. Is the requested drug being prescribed by or in consultation with a dermatologist?
❒ Yes, *Continue to 72*
❒ No, *Continue to 72*

72. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 73*
❒ No, *Continue to 78*

73. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 78*

❒ No, *Continue to 74*

❒ Unknown, *Continue to 78*

74. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 75*
❒ No, *Continue to 77*

75. Has the patient experienced a reduction in body surface area (BSA) affected from baseline? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of decreased body surface area affected.
❒ Yes, *Continue to 157*
❒ No, *Continue to 76*

76. Has the patient experienced an improvement in signs and symptoms of the condition from baseline (e.g., itching, redness, flaking, scaling, burning, cracking, pain)? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of improvement in signs and symptoms.
❒ Yes, *Continue to 157*
❒ No, *Continue to 77*

77. Is this request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose?
❒ Yes, *Continue to 157*
❒ No, *Continue to 157*

78. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Sotyktu, Otezla) indicated for the treatment of moderate to severe plaque psoriasis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.
❒ Yes, *Continue to 157*
❒ No, *Continue to 79*

79. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of affected areas.
❒ Yes, *Continue to 157*
❒ No, *Continue to 80*

80. Is the percentage of body surface area (BSA) affected (prior to starting the requested medication) less than 3%?
❒ Yes, *Continue to 81*
❒ No, *Continue to 81*

81. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)? Indicate percentage. ***ACTION REQUIRED***: Please attach chart notes or medical record documentation of affected areas and body surface area affected.
❒ Greater than or equal to 3% to less than 10% of BSA _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 82*
❒ Greater than or equal to 10% of BSA _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*

82. Has the patient experienced an inadequate response, or has an intolerance to phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 157*
❒ No, *Continue to 83*

83. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 84*
❒ No, *Continue to 84*

84. Please indicate clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin.
❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 157*
❒ Drug interaction, *Continue to 157*
❒ Risk of treatment-related toxicity, *Continue to 157*

❒ Pregnancy or currently planning pregnancy, *Continue to 157*

❒ Breastfeeding, *Continue to 157*

❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 157*

❒ Hypersensitivity, *Continue to 157*

❒ History of intolerance or adverse event, *Continue to 157*

❒ Other, please specify. _____, *Continue to 157*

85. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to 86*
❒ No, *Continue to 86*

86. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 87*
❒ No, *Continue to 89*

87. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 89*

❒ No, *Continue to 88*

❒ Unknown, *Continue to 89*

88. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 157*
❒ No, *Continue to 157*

89. Has the patient ever received or is currently receiving Otezla or a biologic (e.g., Humira) indicated for the treatment of Behcet's disease (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.
❒ Yes, *Continue to 157*
❒ No, *Continue to 90*

90. Has the patient had an inadequate response to at least one non-biologic medication for Behcet's disease (e.g., azathioprine, colchicine, cyclosporine, systemic corticosteroids)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 157*
❒ No, *Continue to 157*

91. Has the patient been diagnosed with severe, refractory hidradenitis suppurativa?
❒ Yes, *Continue to 92*
❒ No, *Continue to 92*

92. Is the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist?
❒ Yes, *Continue to 93*
❒ No, *Continue to 93*

93. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 94*
❒ No, *Continue to 97*

94. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 97*

❒ No, *Continue to 95*

❒ Unknown, *Continue to 97*

95. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 96*
❒ No, *Continue to 96*

96. Which of the following signs and symptoms has the patient experienced an improvement in from baseline?
ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response.
❒ Reduction in abscess and inflammatory nodule count from baseline ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*
❒ Reduced formation of new sinus tracts and scarring ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*
❒ Decrease in frequency of inflammatory lesions from baseline ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*

❒ Reduction in pain from baseline ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*
❒ Reduction in suppuration from baseline ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*
❒ Improvement in frequency of relapses from baseline ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*
❒ Improvement in quality of life from baseline ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*

❒ Improvement on a disease severity assessment tool from baseline ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*

❒ None of the above, *Continue to 157*

97. Has the patient ever received or is currently receiving a biologic (e.g., Humira) indicated for the treatment of severe, refractory hidradenitis suppurativa (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.
❒ Yes, *Continue to 157*
❒ No, *Continue to 98*

98. Has the patient had an inadequate response after at least 90 days of treatment with an oral antibiotic used for the treatment of hidradenitis suppurativa (e.g., clindamycin, metronidazole, moxifloxacin, rifampin, tetracyclines)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 157*
❒ No, *Continue to 99*

99. Has the patient had an intolerance to oral antibiotics used for the treatment of hidradenitis suppurativa? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 157*
❒ No, *Continue to 100*

100. Does the patient have a contraindication to oral antibiotics used for the treatment of hidradenitis suppurativa? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 157*
❒ No, *Continue to 157*

101. Is the requested drug being prescribed by or in consultation with a dermatologist?
❒ Yes, *Continue to 102*
❒ No, *Continue to 102*

102. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 103*
❒ No, *Continue to 105*

103. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 105*

❒ No, *Continue to 104*

❒ Unknown, *Continue to 105*

104. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 157*
❒ No, *Continue to 157*

105. Has the patient ever received or is currently receiving a biologic (e.g., Humira) indicated for the treatment of pyoderma gangrenosum (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.
❒ Yes, *Continue to 157*
❒ No, *Continue to 106*

106. Has the patient had an inadequate response to corticosteroids or immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 157*
❒ No, *Continue to 107*

107. Does the patient have an intolerance or contraindication to corticosteroids and immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, please provide clinical reason to avoid therapy.
❒ Yes, *Continue to 157*
❒ No, *Continue to 157*

108. Is the requested drug being prescribed by or in consultation with a dermatologist, pulmonologist, rheumatologist, cardiologist, neurologist, or ophthalmologist?
❒ Yes, *Continue to 109*
❒ No, *Continue to 109*

109. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 110*
❒ No, *Continue to 112*

110. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 112*

❒ No, *Continue to 111*

❒ Unknown, *Continue to 112*

111. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug or a biosimilar of the requested drug?

❒ Yes, *Continue to 157*
❒ No, *Continue to 157*

112. Has the patient had an inadequate response to corticosteroids or immunosuppressive therapy (e.g., azathioprine, methotrexate)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 157*
❒ No, *Continue to 113*

113. Does the patient have an intolerance or contraindication to corticosteroids and immunosuppressive therapy (e.g., azathioprine, methotrexate)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 157*
❒ No, *Continue to 157*

114. Has the patient been diagnosed with refractory Takayasu's arteritis?
❒ Yes, *Continue to 115*
❒ No, *Continue to 115*

115. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to 116*
❒ No, *Continue to 116*

116. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 117*
❒ No, *Continue to 119*

117. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 119*

❒ No, *Continue to 118*

❒ Unknown, *Continue to 119*

118. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 157*
❒ No, *Continue to 157*

119. Has the patient had an inadequate response to corticosteroids or immunosuppressive therapy (e.g., methotrexate, azathioprine, mycophenolate mofetil)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 157*
❒ No, *Continue to 120*

120. Does the patient have an intolerance or contraindication to corticosteroids and immunosuppressive therapy (e.g., methotrexate, azathioprine, mycophenolate mofetil)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. If therapy is not advisable, please provide clinical reason to avoid therapy.
❒ Yes, *Continue to 157*
❒ No, *Continue to 157*

121. Is the requested drug being prescribed by or in consultation with an ophthalmologist or rheumatologist?
❒ Yes, *Continue to 122*
❒ No, *Continue to 122*

122. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 123*
❒ No, *Continue to 126*

123. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 126*

❒ No, *Continue to 124*

❒ Unknown, *Continue to 126*

124. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 125*
❒ No, *Continue to 125*

125. Which of the following signs and symptoms has the patient experienced an improvement in from baseline? ***ACTION REQUIRED***: Please attach chart notes or medical record documentation supporting positive clinical response.
❒ Reduced frequency of flare recurrence compared to baseline ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*
❒ Zero anterior chamber inflammation or reduction in anterior chamber inflammation compared to baseline ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*
❒ Decreased reliance on topical corticosteroids ***ACTION REQUIRED****: Submit supporting documentation, Continue to 157*

❒ None of the above, *Continue to 157*

126. Has the patient ever received or is currently receiving a biologic (e.g., Humira) indicated for the treatment of uveitis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.
❒ Yes, *Continue to 157*
❒ No, *Continue to 127*

127. Has the patient had an inadequate response with corticosteroids or immunosuppressive therapy (e.g., azathioprine, cyclosporine, methotrexate, mycophenolate mofetil)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medication tried, including response to therapy.
❒ Yes, *Continue to 157*
❒ No, *Continue to 128*

128. Does the patient have an intolerance or contraindication to corticosteroids and immunosuppressive therapy (e.g., azathioprine, cyclosporine, methotrexate, mycophenolate mofetil)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. If therapy is not advisable, please provide clinical reason to avoid therapy.
❒ Yes, *Continue to 157*
❒ No, *Continue to 157*

129. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to 130*
❒ No, *Continue to 130*

130. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 131*
❒ No, *Continue to 133*

131. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 133*

❒ No, *Continue to 132*

❒ Unknown, *Continue to 133*

132. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition (e.g., tender joint count, swollen joint count, pain) since starting treatment with the requested drug or a biosimilar of the requested drug? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation supporting positive clinical response.
❒ Yes, *Continue to 157*
❒ No, *Continue to 157*

133. Has the patient ever received or is currently receiving a biologic (e.g., Enbrel) indicated for the treatment of reactive arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.
❒ Yes, *Continue to 157*
❒ No, *Continue to 134*

134. Has the patient had an inadequate response to methotrexate or sulfasalazine? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 157*
❒ No, *Continue to 135*

135. Does the patient have an intolerance to methotrexate? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 138*
❒ No, *Continue to 136*

136. Does the patient have a contraindication to methotrexate? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 137*
❒ No, *Continue to 137*

137. Please indicate the contraindication to methotrexate.
❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 138*

❒ Drug interaction, *Continue to 138*

❒ Risk of treatment-related toxicity, *Continue to 138*

❒ Pregnancy or currently planning pregnancy, *Continue to 138*

❒ Breastfeeding, *Continue to 138*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 138*

❒ Hypersensitivity, *Continue to 138*

❒ History of intolerance or adverse event, *Continue to 138*

❒ Other, please specify. _____, *Continue to 138*

138. Does the patient have an intolerance to sulfasalazine? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 157*
❒ No, *Continue to 139*

139. Does the patient have a contraindication to sulfasalazine (e.g., porphyria, intestinal or urinary obstruction)? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 157*
❒ No, *Continue to 157*

140. Is the requested drug being prescribed by or in consultation with an oncologist or hematologist?
❒ Yes, *Continue to 141*
❒ No, *Continue to 141*

141. Has the patient had an inadequate response to systemic corticosteroids? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.

❒ Yes, *Continue to 157*
❒ No, *Continue to 142*

142. Does the patient have an intolerance to corticosteroids? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 157*
❒ No, *Continue to 143*

143. Does the patient have a contraindication to corticosteroids? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 157*
❒ No, *Continue to 157*

144. Is the requested drug being prescribed by or in consultation with an oncologist, hematologist, or rheumatologist?
❒ Yes, *Continue to 145*
❒ No, *Continue to 145*

145. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 146*
❒ No, *Continue to 148*

146. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 148*

❒ No, *Continue to 147*

❒ Unknown, *Continue to 148*

147. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation supporting positive clinical response.
❒ Yes, *Continue to 157*
❒ No, *Continue to 157*

148. Does the patient have severe immunotherapy-related inflammatory arthritis?
❒ Yes, *Continue to 149*
❒ No, *Continue to 149*

149. Has the patient had an inadequate response to corticosteroids? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy.
❒ Yes, *Continue to 157*
❒ No, *Continue to 150*

150. Has the patient had an inadequate response to a conventional synthetic drug (e.g., methotrexate, sulfasalazine, leflunomide, hydroxychloroquine)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy.
❒ Yes, *Continue to 157*
❒ No, *Continue to 151*

151. Does the patient have an intolerance or contraindication to corticosteroids? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 152*
❒ No, *Continue to 152*

152. Does the patient have an intolerance or contraindication to a conventional synthetic drug (e.g., methotrexate, sulfasalazine, leflunomide, hydroxychloroquine)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 157*
❒ No, *Continue to 157*

153. Is the requested drug being prescribed by or in consultation with an oncologist or hematologist?
❒ Yes, *Continue to 154*
❒ No, *Continue to 154*

154. Has the patient had an inadequate response to systemic corticosteroids? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 157*
❒ No, *Continue to 155*

155. Does the patient have an intolerance to corticosteroids? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 157*
❒ No, *Continue to 156*

156. Does the patient have contraindication to corticosteroids? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 157*
❒ No, *Continue to 157*

157. What is the diagnosis?

❒ Crohn's disease, *Continue to 158*

❒ Ulcerative colitis, *Continue to 190*

❒ Rheumatoid arthritis, *Continue to 228*

❒ Ankylosing spondylitis, *Continue to 240*

❒ Non-radiographic axial spondyloarthritis, *Continue to 240*
❒ Psoriatic arthritis, *Continue to 252*
❒ Psoriatic arthritis WITH co-existent plaque psoriasis, *Continue to 252*
❒ Plaque psoriasis, *Continue to 252*
❒ Behcet's disease, *Continue to 264*
❒ Hidradenitis suppurativa, *Continue to 264*
❒ Pyoderma gangrenosum, *Continue to 264*
❒ Sarcoidosis, *Continue to 264*
❒ Takayasu's arteritis, *Continue to 264*
❒ Uveitis, *Continue to 269*
❒ Reactive arthritis, *Continue to 264*
❒ Immune checkpoint inhibitor-related toxicity, *Continue to 274*
❒ Immune checkpoint inhibitor-related inflammatory arthritis, *Continue to 264*
❒ Acute graft versus host disease, *Continue to 264*

158. What is the prescribed product?
❒ Avsola, Inflectra, infliximab, Remicade, or Renflexis (intravenous), *Continue to 162*
❒ Zymfentra (subcutaneous), *Continue to 159*

159. What is the patient's age?
❒ Less than 18 years old, *Continue to 160*
❒ 18 years old or older, *Continue to 160*

160. Does the prescribed maintenance dose exceed 120 mg?
❒ Yes, *Continue to 161*
❒ No, *Continue to 161*

161. Is the prescribed frequency for the maintenance dose more frequent than one dose every 2 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

162. Is the patient currently receiving the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 163*
❒ No, *Continue to 183*

163. What is the patient's age?
❒ Less than 18 years old, *Continue to 164*
❒ 18 years old or older, *Continue to 176*

164. Does the prescribed dose exceed 5 mg per kg?

❒ Yes, *Continue to 167*
❒ No, *Continue to 165*

165. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 171*
❒ No, *Continue to 166*

166. What is the patient's weight?
_____ kg, *No further questions*

167. Does the prescribed dose exceed 10 mg per kg?
❒ Yes, *Continue to 168*
❒ No, *Continue to 168*

168. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 171*
❒ No, *Continue to 169*

169. Does the prescriber recognize that a dose above 5 mg per kg every 8 weeks is a higher dose and the prescriber confirms that appropriate monitoring will be done?
❒ Yes, *Continue to 170*
❒ No, *Continue to 170*

170. What is the patient's weight?
_____kg, *No further questions*

171. Please select the situation that applies to the patient.
❒ Patient is continuing therapy at current dose and/or frequency, *Continue to 173*
❒ Prescriber is increasing dose and/or frequency, *Continue to 172*
❒ Prescriber is decreasing dose and/or frequency, *Continue to 173*

172. Is this a request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose and/or frequency?
❒ Yes, *Continue to 173*
❒ No, *Continue to 173*

173. Does the prescribed dose and frequency exceed 10 mg per kg every 4 weeks?
❒ Yes, *Continue to 174*
❒ No, *Continue to 174*

174. Does the prescriber recognize that a dose above 5 mg per kg every 8 weeks is a higher dose and the prescriber confirms that appropriate monitoring will be done?
❒ Yes, *Continue to 175*
❒ No, *Continue to 175*

175. What is the patient's weight?

_____ kg, *No further questions*

176. Does the prescribed dose exceed 5 mg per kg?
❒ Yes, *Continue to 179*
❒ No, *Continue to 177*

177. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 179*
❒ No, *Continue to 178*

178. What is the patient's weight?

_____ kg, *No further questions*

179. Please select the situation that applies to the patient.

❒ Patient is continuing therapy at current dose and/or frequency, *Continue to 181*

❒ Prescriber is increasing dose and/or frequency, *Continue to 180*

❒ Prescriber is decreasing dose and/or frequency, *Continue to 181*

180. Is this a request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose or frequency?
❒ Yes, *Continue to 181*
❒ No, *Continue to 181*

181. Does the prescribed dose and frequency exceed 10 mg per kg every 4 weeks?
❒ Yes, *Continue to 182*
❒ No, *Continue to 182*

182. What is the patient's weight? Indicate units.

_____ kg, *No further questions*

183. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 184*
❒ No, *Continue to 184*

184. Does the prescribed dose exceed an induction dose of 5 mg per kg at week 0, week 2, and week 6, and a maintenance dose of 5 mg per kg thereafter?
❒ Yes, *Continue to 186*
❒ No, *Continue to 185*

185. What is the patient's weight.

_____ kg, *No further questions*

186. What is the patient's age?

❒ Less than 18 years old, *Continue to 187*

❒ 18 years of age or older, *Continue to 187*

187. Does the prescriber recognize that a dose above 5 mg per kg every 8 weeks is a higher dose and the prescriber confirms that appropriate monitoring will be done?
❒ Yes, *Continue to 188*
❒ No, *Continue to 188*

188. Does the prescribed dose exceed an induction dose of 10 mg per kg at week 0, week 2, and week 6, and a maintenance dose of 10 mg per kg thereafter?
❒ Yes, *Continue to 189*
❒ No, *Continue to 189*

189. What is the patient's weight?

_____ kg, *No further questions*

190. What is the prescribed product?

❒ Avsola, Inflectra, infliximab, Remicade, or Renflexis (intravenous), *Continue to 194*

❒ Zymfentra (subcutaneous), *Continue to 191*

191. What is the patient's age?

❒ Less than 18 years old, *Continue to 192*

❒ 18 years old or older, *Continue to 192*

192. Does the prescribed maintenance dose exceed 120 mg?
❒ Yes, *Continue to 193*
❒ No, *Continue to 193*

193. Is the prescribed frequency for the maintenance dose more frequent than one dose every 2 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

194. Is the patient currently receiving the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 195*
❒ No, *Continue to 221*

195. What is the patient's age?

❒ Less than 18 years old, *Continue to 196*

❒ 18 years old or older, *Continue to 208*

196. Does the prescribed dose exceed 5 mg per kg?

❒ Yes, *Continue to 199*
❒ No, *Continue to 197*

197. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 203*
❒ No, *Continue to 198*

198. What is the patient's weight?
_____ kg, *No further questions*

199. Does the prescribed dose exceed 10 mg per kg?
❒ Yes, *Continue to 200*
❒ No, *Continue to 200*

200. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 203*
❒ No, *Continue to 201*

201. Does the prescriber recognize that a dose above 5 mg per kg every 8 weeks is a higher dose and the prescriber confirms that appropriate monitoring will be done?
❒ Yes, *Continue to 202*
❒ No, *Continue to 202*

202. What is the patient's weight?
_____ kg, *No further questions*

203. Please select the situation that applies to the patient.
❒ Patient is continuing therapy at current dose and/or frequency, *Continue to 205*
❒ Prescriber is increasing dose and/or frequency, *Continue to 204*
❒ Prescriber is decreasing dose and/or frequency, *Continue to 205*

204. Is this a request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose or frequency?
❒ Yes, *Continue to 205*
❒ No, *Continue to 205*

205. Does the prescribed dose and frequency exceed 10 mg per kg every 4 weeks?
❒ Yes, *Continue to 206*
❒ No, *Continue to 206*

206. Does the prescriber recognize that a dose above 5 mg per kg every 8 weeks is a higher dose and the prescriber confirms that appropriate monitoring will be done?
❒ Yes, *Continue to 207*
❒ No, *Continue to 207*

207. What is the patient's weight?

_____kg, *No further questions*

208. Does the prescribed dose exceed 5 mg per kg?
❒ Yes, *Continue to 211*
❒ No, *Continue to 209*

209. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 217*
❒ No, *Continue to 210*

210. What is the patient's weight?

_____ kg, *No further questions*

211. Was the patient on a dose exceeding 5 mg per kg as a pediatric patient and is continuing that dose into adulthood?
❒ Yes, *Continue to 214*
❒ No, *Continue to 212*

212. Please select the situation that applies to the patient.

❒ Patient is continuing therapy at current dose, *Continue to 214*

❒ Prescriber is increasing dose, *Continue to 213*

❒ Prescriber is decreasing dose, *Continue to 214*

213. Is this a request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose?
❒ Yes, *Continue to 214*
❒ No, *Continue to 214*

214. Does the prescribed dose exceed 10 mg per kg?
❒ Yes, *Continue to 215*
❒ No, *Continue to 215*

215. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 217*
❒ No, *Continue to 216*

216. What is the patient's weight?

_____ kg, *No further questions*

217. Please select the situation that applies to the patient.

❒ Patient is continuing therapy at current frequency, *Continue to 219*

❒ Prescriber is increasing frequency, *Continue to 218*

❒ Prescriber is decreasing frequency, *Continue to 219*

218. Is this a request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose or frequency?
❒ Yes, *Continue to 219*
❒ No, *Continue to 219*

219. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *Continue to 220*
❒ No, *Continue to 220*

220. What is the patient's weight?

_____ kg, *No further questions*

221. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 222*
❒ No, *Continue to 222*

222. Does the prescribed dose exceed an induction dose of 5 mg per kg at week 0, week 2, and week 6, and 5 mg per kg thereafter?
❒ Yes, *Continue to 224*
❒ No, *Continue to 223*

223. What is the patient's weight?

_____ kg, *No further questions*

224. What is the patient's age?

❒ Less than 18 years old, *Continue to 225*

❒ 18 years of age or older, *Continue to 225*

225. Does the prescriber recognize that a dose above 5 mg per kg every 8 weeks is a higher dose and the prescriber confirms that appropriate monitoring will be done?
❒ Yes, *Continue to 226*
❒ No, *Continue to 226*

226. Does the prescribed dose exceed an induction dose of 10 mg per kg at week 0, week 2, and week 6, and a maintenance dose of 10 mg per kg thereafter?
❒ Yes, *Continue to 227*
❒ No, *Continue to 227*

227. What is the patient's weight?

_____ kg, *No further questions*

228. What is the prescribed product?

❒ Avsola, Inflectra, infliximab, Remicade, or Renflexis (intravenous), *Continue to 229*

❒ Zymfentra (subcutaneous), *Continue to 229*

229. Is the patient currently receiving the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 230*
❒ No, *Continue to 237*
230. Does the prescribed dose exceed 3 mg per kg?
❒ Yes, *Continue to 233*
❒ No, *Continue to 231*
231. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 233*
❒ No, *Continue to 232*

232. What is the patient's weight?

_____ kg, *No further questions*

233. Please select the situation that applies to the patient.

❒ Patient is continuing therapy at current dose and/or frequency, *Continue to 235*

❒ Prescriber is increasing dose and/or frequency, *Continue to 234*

❒ Prescriber is decreasing dose and/or frequency, *Continue to 235*

234. Is this a request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose or frequency?
❒ Yes, *Continue to 235*
❒ No, *Continue to 235*
235. Does the prescribed dose and frequency exceed 10 mg per kg every 4 weeks?
❒ Yes, *Continue to 236*
❒ No, *Continue to 236*

236. What is the patient's weight?

_____ kg, *No further questions*

237. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 238*
❒ No, *Continue to 238*
238. Does the prescribed dose exceed an induction dose of 3 mg per kg at week 0, week 2, and week 6, and a maintenance dose of 3 mg per kg thereafter?
❒ Yes, *Continue to 239*
❒ No, *Continue to 239*

239. What is the patient's weight?

_____ kg, *No further questions*

240. What is the prescribed product?

❒ Avsola, Inflectra, infliximab, Remicade, or Renflexis (intravenous), *Continue to 241*

❒ Zymfentra (subcutaneous), *Continue to 241*

241. Is the patient currently receiving the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 242*
❒ No, *Continue to 249*
242. Does the prescribed dose exceed 5 mg per kg?
❒ Yes, *Continue to 245*
❒ No, *Continue to 243*
243. Is the prescribed frequency for the maintenance dose more frequent than one dose every 6 weeks?
❒ Yes, *Continue to 245*
❒ No, *Continue to 244*

244. What is the patient's weight?

_____ kg, *No further questions*

245. Please select the situation that applies to the patient.

❒ Patient is continuing therapy at current dose and/or frequency, *Continue to 247*

❒ Prescriber is increasing dose and/or frequency, *Continue to 246*

❒ Prescriber is decreasing dose and/or frequency, *Continue to 247*

246. Is this a request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose or frequency?
❒ Yes, *Continue to 247*
❒ No, *Continue to 247*
247. Does the prescribed dose and frequency exceed 7.5 mg per kg every 4 weeks?
❒ Yes, *Continue to 248*
❒ No, *Continue to 248*

248. What is the patient's weight?

_____ kg, *No further questions*

249. Is the prescribed frequency for the maintenance dose more frequent than one dose every 6 weeks?
❒ Yes, *Continue to 250*
❒ No, *Continue to 250*

250. Does the prescribed dose exceed an induction dose of 5 mg per kg at week 0, week 2, and week 6, and 5 mg per kg thereafter?
❒ Yes, *Continue to 251*
❒ No, *Continue to 251*

251. What is the patient's weight?.

_____ kg, *No further questions*

252. What is the prescribed product?

❒ Avsola, Inflectra, infliximab, Remicade, or Renflexis (intravenous), *Continue to 253*

❒ Zymfentra (subcutaneous), *Continue to 253*

253. Is the patient currently receiving the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 254*
❒ No, *Continue to 261*

254. Does the prescribed dose exceed 5 mg per kg?
❒ Yes, *Continue to 257*
❒ No, *Continue to 255*

255. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 257*
❒ No, *Continue to 256*

256. What is the patient's weight?

_____ kg, *No further questions*

257. Please select the situation that applies to the patient.

❒ Patient is continuing therapy at current dose and/or frequency, *Continue to 259*

❒ Prescriber is increasing dose and/or frequency, *Continue to 258*

❒ Prescriber is decreasing dose and/or frequency, *Continue to 259*

258. Is this a request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose or frequency?
❒ Yes, *Continue to 259*
❒ No, *Continue to 259*

259. Does the prescribed dose and frequency exceed 10 mg per kg every 4 weeks?
❒ Yes, *Continue to 260*
❒ No, *Continue to 260*

260. What is the patient's weight?

_____ kg, *No further questions*

261. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 262*
❒ No, *Continue to 262*
262. Does the prescribed dose exceed an induction dose of 5 mg per kg at week 0, week 2, and week 6, and 5 mg per kg thereafter?
❒ Yes, *Continue to 263*
❒ No, *Continue to 263*

263. What is the patient's weight?

_____ kg, *No further questions*

264. What is the prescribed product?

❒ Avsola, Inflectra, infliximab, Remicade, or Renflexis (intravenous), *Continue to 265*

❒ Zymfentra (subcutaneous), *Continue to 265*

265. Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?
❒ Yes, *Continue to 266*
❒ No, *Continue to 266*
266. Is the patient currently receiving the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 267*
❒ No, *Continue to 268*

267. What is the patient's weight?

_____ kg, *No further questions*

268. What is the patient's weight?

_____ kg, *No further questions*

269. What is the prescribed product?

❒ Avsola, Inflectra, infliximab, Remicade, or Renflexis (intravenous), *Continue to 270*

❒ Zymfentra (subcutaneous), *Continue to 270*

270. Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?
❒ Yes, *Continue to 271*
❒ No, *Continue to 271*
271. Is the patient currently receiving the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 272*
❒ No, *Continue to 273*

272. What is the patient's weight?

_____ kg, *No further questions*

273. What is the patient's weight?

_____ kg, *No further questions*

274. What is the prescribed product?

❒ Avsola, Inflectra, infliximab, Remicade, or Renflexis (intravenous), *Continue to 275*

❒ Zymfentra (subcutaneous), *Continue to 275*

275. Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?
❒ Yes, *Continue to 276*
❒ No, *Continue to 276*
276. Is the patient currently receiving the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 277*
❒ No, *Continue to 278*

277. What is the patient's weight?

_____ kg, *No further questions*

278. What is the patient's weight?

_____ kg, *No further questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Priority Partners Fax: 1-866-212-4756

 JHHC Remicade and biosimilars MR SOC SGM 4940-D, 2182-A – 02/2024.