TRICARE Prior Authorization Request Form for
infliximab-dyyb SQ (Zymfentra)

JOHNS HOPKINS
HEALTH PLANS
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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization does not expire.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is the patient 18 years of age or older?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Does the patient have moderately to severely active ulcerative colitis or moderately to severely active Crohn's disease?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Humira is the Department of Defense's preferred targeted biologic agent for ulcerative colitis and Crohn's disease. Has the patient tried Humira (adalimumab)?	☐ Yes Proceed to question **4**	☐ No Proceed to question **6**
4. Has the patient had an inadequate response to Humira?	☐ Yes Proceed to question **8**	☐ No Proceed to question **5**
5. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes Proceed to question **8**	☐ No Proceed to question **6**
6. Does the patient have a contraindication to Humira?	☐ Yes Proceed to question **8**	☐ No Proceed to question **7**
7. Is the patient clinically stable on intravenous (IV) infliximab and changing to Humira would incur unacceptable risk?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**

8. Has the patient received infliximab product administered intravenously as induction therapy and has demonstrated positive response?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Has the patient had an inadequate response to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [such as, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [for example, azathioprine], etc.)	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Does the patient have evidence of a negative Tuberculosis (TB) test result in the past 12 months (or TB is adequately managed)?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Will the patient be receiving any other targeted immunomodulatory biologics with infliximab-dyyb (Zymfentra) including but not limited to the following: certolizumab (Cimzia), etanercept (Enbrel), golimumab (Simponi), infliximab (Remicade), apremilast (Otezla), ustekinumab (Stelara), abatacept (Orencia), anakinra (Kineret), tocilizumab (Actemra), tofacitinib (Xeljanz/Xeljanz XR), rituximab (Rituxan), secukinumab (Cosentyx), ixekizumab (Taltz), brodalumab (Siliq), sarilumab (Kevzara), guselkumab (Tremfya), baricitinib (Olumiant), tildrakizumab (Ilumya), risankizumab (Skyrizi), upadacitinib (Rinvoq ER), or vedolizumab (Entyvio)?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

STEP 3 **I certify the above is true to the best of my knowledge.** Please sign and date.

Prescriber Signature _____ Date _____

[14 August 2024]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: