Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Avsola (infliximab-axxq)
Inflectra (infliximab-dyyb)
Remicade (infliximab)
Renflexis (infliximab-adba)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested: ICD10:
☐ Avsola 100mg vial ☐ Inflectra 100mg vial
☐ Remicade 100mg vial ☐ Renflexis 100mg vial
☐ Other (*please specify*):

Directions for use: Dose: Quantity: Duration of therapy:

What is your patient's current weight?
Is this a new start or continuation of therapy? If changing from Remicade to Avsola, Inflectra or Renflexis, please choose "new start of therapy". If your patient has already begun treatment with drug samples of Avsola, Inflectra, or Renflexis, please choose "new start of therapy". ☐ new start of therapy ☐ continued therapy

If continued therapy:
Has your patient had a good response to therapy with this drug (such as improvement or remission)? ☐ Yes ☐ No
(if no) Please provide clinical support for the continued use of the requested drug:

(fi continued therapy) Which applies to your patient?
☐ patient is established on this drug with previous approval by Cigna
☐ patient is established on this drug with previous approval by another health plan
☐ patient is established on this drug with regular use for more than 1 year
☐ patient was previously established on this drug, and is restarting after a break in therapy
☐ other
Please provide the dates your patient has received the requested drug:

Besides the drug being requested, other biological drugs include Actemra, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Renflexis, Rinvoq, Rituxan, Siliq, Simponi/Simponi Aria, Stelara, Taltz, Tremfya, Tysabri, and Xeljanz/Xeljanz XR. Which of the following best describes your patient's situation?
☐ The patient is NOT taking any other biological at this time, nor will they in the future. The requested drug is the only biological the patient is/will be using.
☐ The patient is currently on another biological, but this drug will be stopped and the requested drug will be started.
☐ The patient is currently on another biological, and the requested drug will be added. The patient may continue to take both drugs together.
☐ The patient is currently on BOTH the requested drug AND another biological.
☐ other/unknown
(if other/more than the requested drug) Please provide name of drug, dates taken and, if applicable, the clinical rationale for the combined use of the requested drug and another biologic to treat your patient's diagnosis.

Where will this medication be obtained?

☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:

Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

NOTE: *Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting .*

Is this infusion occurring in a facility affiliated with hospital outpatient setting? ☐ Yes ☐ No

If yes- Is this patient a candidate for re-direction to an alternate setting after 1-2 infusions (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use (please specify):

☐ Ankylosing Spondylitis (AS, axial spondyloarthropathy)
☐ Behcet's disease
☐ Chronic Plaque Psoriasis (CPP, PsO, psoriasis vulgaris)
☐ Crohn's Disease (CD, regional enteritis)
☐ Graft Versus Host Disease (GVHD)
☐ Hidradenitis Suppurativa (HS)
☐ Immune Checkpoint Inhibitor (ICI)* therapy related adverse events (*Bavencio, Imfinzi, Keytruda, Opdivo, Tecentriq, Yervoy)
☐ Indeterminate Colitis
☐ Polyarticular Juvenile Idiopathic Arthritis (pJIA)
☐ Psoriatic Arthritis (PsA)
☐ Pyoderma Gangrenosum (PG)
☐ Rheumatoid Arthritis (RA)
☐ Sarcoidosis
☐ Scleritis
☐ Still's disease
☐ Ulcerative Colitis (UC)
☐ Uveitis (including intermediate, posterior and panuveitis)
☐ other:

Clinical Information:

(if any DX except PJIA) Has the patient already received a biologic for their condition? ☐ Yes ☐ No
(if AS) Is there documentation that your patient either has had failure, inadequate response or intolerance OR has a contraindication per FDA label OR is not a candidate for at least one nonsteroidal anti-inflammatory drug (NSAID)? ☐ Yes ☐ No
(if AS) Is this drug being prescribed by, or in consultation with, a rheumatologist or a prescriber who specializes in ankylosing spondylitis? ☐ Yes ☐ No

(if Behcet's disease) Is there documentation that your patient either has had failure or inadequate response, contraindication per FDA label, intolerance, or is NOT a candidate for at least ONE systemic conventional therapy (for example, corticosteroids [e.g., methylprednisolone], immunosuppressants [e.g., azathioprine, methotrexate, mycophenolate mofetil, cyclosporine, tacrolimus], colchicine)? ☐ Yes ☐ No
(if no) Does the patient have ophthalmic manifestations of Behcet's disease? ☐ Yes ☐ No
(if Behcet's disease) Is this drug being prescribed by, or in consultation with, a rheumatologist, dermatologist, ophthalmologist, gastroenterologist, neurologist, or prescriber who specializes in Behcet's disease? ☐ Yes ☐ No

(if Crohn's) Does your patient have moderate to severe disease? ☐ Yes ☐ No
(if Crohn's) Does your patient have either of the following?
☐ enterocutaneous (perianal or abdominal) or rectovaginal fistulas
☐ individual has had an ileocolonic resection (to reduce the chance of Crohn's disease recurrence)
☐ none of the above or unknown

(if Crohn's) Is there documentation that the requested drug will be taken together with either a corticosteroid (for example, prednisone, methylprednisolone) or a conventional systemic therapy [for example, azathioprine, 6-mercaptopurine, methotrexate (MTX)]? ☐ Yes ☐ No

(if no) Is there documentation that your patient either has had failure, inadequate response or intolerance OR has a contraindication per FDA label OR is not a candidate for either of the following?
☐ a corticosteroid (for example, prednisone, methylprednisolone)

☐ a conventional systemic therapy [for example, azathioprine, 6-mercaptopurine, methotrexate (MTX)]
☐ none of the above or unknown

(if Crohn's) Is this drug being prescribed by, or in consultation with, a gastroenterologist or a prescriber who specializes in Crohn's disease? ☐ Yes ☐ No

(if GVHD) Is there documentation that the requested drug will be taken together with one conventional treatment (for example, high-dose systemic corticosteroids, antithymocyte globulin, cyclosporine, thalidomide, tacrolimus, mycophenolate mofetil)? ☐ Yes ☐ No

(if no) Is there documentation that your patient either has had failure, inadequate response or intolerance OR has a contraindication per FDA label OR is not a candidate for ONE conventional treatment (for example, high-dose systemic corticosteroids, antithymocyte globulin, cyclosporine, thalidomide, tacrolimus, mycophenolate mofetil)? ☐ Yes ☐ No

(if GVHD) Is this drug being prescribed by, or in consultation with, an oncologist, hematologist, or a physician affiliated with a transplant center? ☐ Yes ☐ No

(if HS) Does your patient have moderate to severe disease? ☐ Yes ☐ No

if HS) Is there documentation that your patient either has had failure, inadequate response or intolerance OR has a contraindication per FDA label OR is not a candidate for ONE conventional treatment [for example, isotretinoin, intralesional or oral corticosteroids (such as triamcinolone, prednisone), systemic antibiotics (for example, clindamycin, dicloxacillin, erythromycin)]? ☐ Yes ☐ No

(if HS) Is this drug being prescribed by, or in consultation with, a dermatologist or a prescriber who specializes in hidradenitis suppurativa? ☐ Yes ☐ No

(if Immune checkpoint inhibitor) Was your patient receiving a checkpoint inhibitor (for example, Bavencio, Imfinzi, Keytruda, Opdivo, Tecentriq, or Yervoy)? ☐ Yes ☐ No

(if yes) Did your patient develop an immunotherapy-related toxicity due to this therapy? ☐ Yes ☐ No

(if yes) Does it involve any of the following: gastrointestinal system (for example, colitis), inflammatory arthritis, or ocular toxicity (for example, uveitis/iritis, episcleritis, blepharitis)? ☐ Yes ☐ No

(if Immune checkpoint inhibitor) Is there documentation that your patient either has had failure, inadequate response or intolerance OR has a contraindication per FDA label OR is not a candidate for ONE steroid (for example, methylprednisolone, prednisone)? ☐ Yes ☐ No

(if Immune checkpoint inhibitor) Is this drug being prescribed by, or in consultation with, an oncologist, gastroenterologist, rheumatologist, or ophthalmologist? ☐ Yes ☐ No

(if Indeterminate colitis) Is there documentation that your patient either has had failure, inadequate response, or intolerance OR has a contraindication per FDA label OR is not a candidate for any of the following:
A) Systemic corticosteroid (for example, prednisone, methylprednisolone);
B) Mesalamine;
C) Azathioprine or 6-mercaptopurine? ☐ Yes ☐ No

(if Indeterminate colitis) Is this drug being prescribed by, or in consultation with, a gastroenterologist? ☐ Yes ☐ No

(if CPP or PsA) Does your patient have BOTH chronic plaque psoriasis (CPP) AND psoriatic arthritis (PsA)?
☐ Yes (answer all questions for both CPP and PsA)
☐ No, only CPP
☐ No, only PsA

(if CPP) Does your patient have ONE of the following?
☐ Affected BSA (body surface area) is greater than 5%
☐ Affected BSA is less than 5% AND the following area(s) are involved: scalp, face, the palms and soles (palmoplantar disease), or genitals
☐ None of the above

(if CPP) Is there documentation that your patient either has had failure, inadequate response or intolerance OR has a contraindication per FDA label OR is not a candidate for either of the following?
☐ systemic therapy (for example, methotrexate, cyclosporine, Soriatane)
☐ phototherapy [narrow or broad band ultraviolet B (UVB), or psoralen plus ultraviolet A (PUVA)]
☐ topical therapy (for example, coal tar, keratolytics, corticosteroids, anthralin, Dovonex, Tazorac)
☐ MORE THAN ONE of the above
☐ none of the above or unknown

(if CPP) Is this drug being prescribed by, or in consultation with, a dermatologist or a prescriber who specializes in plaque psoriasis? ☐ Yes ☐ No

(if PJIA) Is this drug being prescribed by, or in consultation with, a rheumatologist or a prescriber who specializes in PJIA? ☐ Yes ☐ No

(if PsA) Is there documentation that your patient either has had failure, inadequate response or intolerance OR has a contraindication per FDA label OR is not a candidate for ONE disease-modifying anti-rheumatic drug (DMARD) (for example, methotrexate, leflunomide, sulfasalazine)? ☐ Yes ☐ No

(if PsA) Is this drug being prescribed by, or in consultation with, a rheumatologist, dermatologist or a prescriber who specializes in psoriatic arthritis? ☐ Yes ☐ No

(if pyoderma gangrenosum) Does the patient have documented failure or inadequate response, contraindication per FDA label, intolerance, or is not a candidate for one systemic corticosteroid (for example, prednisone) AND one topical corticosteroid? ☐ Yes ☐ No

(if no) Is there documentation that your patient tried an immunosuppressant (for example, mycophenolate mofetil or cyclosporine) for at least 2 months AND one topical corticosteroid, but had failure or inadequate response? ☐ Yes ☐ No

(if no) Is there documentation that your patient either had intolerance OR has a contraindication per FDA label OR is not a

candidate for an immunosuppressant (for example, mycophenolate mofetil or cyclosporine) AND one topical corticosteroid? ☐ Yes ☐ No

(if pyoderma gangrenosum) Is this drug being prescribed by, or in consultation with, a dermatologist, rheumatologist or prescriber who specializes in pyoderma gangrenosum? ☐ Yes ☐ No

(if RA) Is there documentation that your patient either has had failure or inadequate response, contraindication per FDA label, intolerance, or not a candidate for one disease-modifying anti-rheumatic drug (DMARD) (for example: methotrexate, leflunomide, sulfasalazine)? ☐ Yes ☐ No

(if RA) Is this drug being prescribed by, or in consultation with, a rheumatologist or a prescriber who specializes in rheumatoid arthritis? ☐ Yes ☐ No

(if Sarcoidosis) Is there documentation that your patient either has had failure, inadequate response or intolerance OR has a contraindication per FDA label OR is not a candidate for ONE corticosteroid? ☐ Yes ☐ No

(if Sarcoidosis) Is there documentation that your patient either has had failure, inadequate response or intolerance OR has a contraindication per FDA label OR is not a candidate for ONE immunosuppressant (for example, methotrexate, cyclophosphamide, azathioprine)? ☐ Yes ☐ No

(if Sarcoidosis) Is this drug being prescribed by, or in consultation with, a pulmonologist, ophthalmologist, dermatologist, rheumatologist or a prescriber who specializes in sarcoidosis? ☐ Yes ☐ No

(if Scleritis) Is there documentation that your patient either has had failure, inadequate response or intolerance OR has a contraindication per FDA label OR is not a candidate for one other therapy for this condition [for example, oral NSAIDs (for example, indomethacin), oral, ophthalmic or IV corticosteroids (for example, prednisone, prednisolone, methylprednisolone); methotrexate; cyclosporine; or other immunosuppressants]? ☐ Yes ☐ No

(if Scleritis) Is this drug being prescribed by, or in consultation with, an ophthalmologist? ☐ Yes ☐ No

(if Still's) Is there documentation that your patient either has had failure, inadequate response or intolerance OR has a contraindication per FDA label OR is not a candidate for one corticosteroid (for example, prednisone)? ☐ Yes ☐ No

(if Still's) Is there documentation that your patient tried ONE conventional synthetic disease-modifying anti-rheumatic drug (DMARD) (for example, methotrexate) for at least 2 months, but had failure or inadequate response? ☐ Yes ☐ No

(if no) Is there documentation that your patient either had intolerance OR has a contraindication per FDA label OR is not a candidate for ONE conventional synthetic disease-modifying anti-rheumatic drug (DMARD) (for example, methotrexate)? ☐ Yes ☐ No

(if Still's) Is this drug being prescribed by, or in consultation with, a rheumatologist or a prescriber who specializes in Still's Disease? ☐ Yes ☐ No

(if UC) Does the patient have documented failure or inadequate response, contraindication per FDA label, intolerance, or is not a candidate for at least ONE conventional therapy (for example, aminosalicylate, corticosteroids or immunosuppressants)? ☐ Yes ☐ No

(if UC) Does the patient have pouchitis and has tried therapy an antibiotic (for example, metronidazole, ciprofloxacin), corticosteroid enema, or mesalamine enema? ☐ Yes ☐ No

(if UC) Is this drug being prescribed by, or in consultation with, a gastroenterologist or a prescriber who specializes in ulcerative colitis? ☐ Yes ☐ No

(if Uveitis) Is there documentation that your patient either has had failure, inadequate response or intolerance OR has a contraindication per FDA label OR is not a candidate for conventional therapy [such as corticosteroids or immunosuppressive drugs (for example, azathioprine, cyclosporine, or methotrexate)]? ☐ Yes ☐ No

(if Uveitis) Is this drug being prescribed by, or in consultation with, an ophthalmologist, rheumatologist or a prescriber who specializes in uveitis? ☐ Yes ☐ No

Which of the following anti-tumor necrosis factor (TNF) biologics has your patient tried for this diagnosis? (Check all that apply)

☐ Avsola ☐ Cimzia ☐ Enbrel ☐ Humira ☐ Inflectra ☐ Otezla ☐ Remicade ☐ Renflexis ☐ Simponi 50mg ☐ Simponi 100mg ☐ Simponi Aria

For all drugs checked above, please provide drug name(s), date(s) taken and details of the documented results (including any intolerances experienced) for each drug tried:

Is there a documented reason that your patient is not a candidate for or is unable to use (including contraindication per FDA label) to any of the following? (check all that apply):

☐ Avsola ☐ Cimzia ☐ Enbrel ☐ Humira ☐ Inflectra ☐ Otezla ☐ Remicade ☐ Renflexis ☐ Simponi 50mg ☐ Simponi 100mg ☐ Simponi Aria

For all drugs checked above, please provide drug name(s) and detailed reasons why the drug(s) can't be tried:

Which of the following infliximab products has your patient tried? (Check all that apply):

☐ Avsola ☐ Inflectra ☐ Renflexis ☐ Remicade

For all the drugs tried above, please provide drug name(s), date(s) taken and details of the trial. If your patient has stopped these drugs, please include the reason.

Please provide clinical rationale for the use of this drug for your patient (pertinent patient history, alternatives tried, any inability to use alternatives above or standard therapy, etc). Please include drug name(s), date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced.

Additional pertinent information: *Please include any alternatives tried, with drug name, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced.*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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