# Clinical Criteria Worksheet:
# Infliximab Products

## Claim Submission

- Claim processing may be delayed if the information submitted in this worksheet is illegible.
- If the worksheet is left blank or information is missing the claim will be rejected for not enough documentation and reimbursement will be delayed.
- A claim should not be submitted until the drug has been administered to the patient.
- The manufacturer invoice showing the acquisition cost of the drug administered, including all discounts, rebates, and incentives must be submitted with the claim. The invoice must be dated within 6 months prior to the date of service and/or should include the expiration date of the drug, or it will be rejected for not enough documentation.

## Enrollee Information

**Enrollee Last Name:**

**Enrollee First Name:**

**Date of Birth (MM/DD/YYYY):**

/ /

**Enrollee Medicaid ID (2 letters, 5 numbers, 1 letter):**

**Address:**

**City, Town or Post Office:**

**State:**

**ZIP Code:**

## Prescriber Information

**Prescriber Last Name:**

**Prescriber First Name:**

**National Provider Identifier (NPI) Number:**

**Preferred Contact (Telephone Number)**

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**Enrollee Last Name:**

**Enrollee First Name:**

## Clinical Criteria – Drug Information

**Drug Administration:**

Provide the date of drug administration (MM/DD/YYYY):

__ __ / __ __ / __ __ __ __

Provide the expiration date of the drug if the invoice date is greater than 6 months from the date of drug administration (MM/DD/YYYY):

__ __ / __ __ / __ __ __ __

**Drug Name and Strength:**

☐ infliximab (REMICADE®) 100 mg vial

☐ infliximab 100 mg vial

☐ infliximab-abda (RENFLEXIS®) 100 mg vial

☐ infliximab-axxq (AVSOLA®) 100 mg vial

☐ infliximab-dyyb (INFLECTRA®) 100 mg vial

**Quantity:** _____

**Directions:** _____

**New Treatment:** ☐ Yes ☐ No

If **No**, date therapy initiated: _____

**Enrollee Last Name:**

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**Enrollee First Name:**

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## Clinical Criteria – Diagnosis

1. Diagnosis related to use (please select one diagnosis):

   Food and Drug Administration Approved Indications:

   - ☐ Ankylosing spondylitis
   - ☐ Crohn's disease/ fistulizing Crohn's disease
   - ☐ Psoriatic arthritis
   - ☐ Plaque psoriasis
   - ☐ Rheumatoid arthritis, in combination with methotrexate (MTX)
   - ☐ Ulcerative colitis

   Compendia-Supported Uses

   - ☐ Adult-onset Still's disease
   - ☐ Behcet's syndrome
   - ☐ Graft versus host disease
   - ☐ Refractory granulomatosis with polyangiitis, in combination with corticosteroids
   - ☐ Severe, refractory hidradenitis suppurativa
   - ☐ Refractory Kawasaki disease
   - ☐ Severe, refractory synovitis, acne, pustulosis, hyperostosis, and osteitis syndrome (SAPHO syndrome)
   - ☐ Refractory sarcoidosis (Adjunctive therapy)
   - ☐ Synovitis
   - ☐ Refractory Takayasu's disease
   - ☐ Refractory uveitis (Adjunctive therapy)
   - ☐ Other: _____



2. Was the patient's medication record reviewed to confirm that the patient is not utilizing infliximab with other biological products to treat the same condition?

☐ Yes ☐ No

**Enrollee Last Name:**

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**Enrollee First Name:**

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## Clinical Criteria

3. Please indicate if this request is for the initiation or continuation of infliximab therapy?

☐ Initiation ☐ Continuation

4. Prior to initiation of infliximab therapy, has the patient had a trial of a disease-modifying antirheumatic drug (DMARD) OR a tumor necrosis factor inhibitor (TNFi)?

☐ Yes ☐ No



## Attestation

*I attest that this drug is medically necessary for this patient and that all of the information on this form is accurate to the best of my knowledge. I attest that documentation of the above diagnosis and medical necessity is available for review if requested by the New York State Medicaid Program.*

**Prescriber Signature (Required)** **Date (MM/DD/YYYY)**