Clinical Criteria Worksheet:
Infliximab Products

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): _____

Clinical Criteria – Drug Information

Drug Administration:

Provide 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

Enrollee Last Name: **Enrollee First Name:**

_____ _____

Clinical Criteria – Diagnosis

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

   Food and Drug Administration Approved Indications:

   - ☐ Ankylosing spondylitis
   - ☐ Psoriatic arthritis
   - ☐ Plaque psoriasis
   - ☐ Rheumatoid arthritis, in combination with methotrexate (MTX)

   Compendia-Supported Uses

   - ☐ Adult-onset Still's disease
   - ☐ Behcet's syndrome
   - ☐ Graft versus host disease
   - ☐ Polyarteritis Nodosa
   - ☐ 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
   - ☐ Uveitis and 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: **Enrollee First Name:**

_____ _____

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 conventional agent, disease-modifying antirheumatic drug (DMARD) OR a tumor necrosis factor inhibitor (TNFi)?

   ☐ Yes ☐ No

   *Step Therapy does not apply to Ulcerative Colitis and Chrohn's disease.

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)**