aetna®

MEDICARE FORM

Avsola™ (infliximab-axxq) Injectable Medication Precertification Request

(All fields must be completed and legible for precertification review.)

For Medicare Advantage Part B:
Phone: 1-866-503-0857 (TTY: 711)
FAX: 1-844-268-7263

For other lines of business:
Please use other form.

Note: Avsola is non-preferred. Preferred products vary based on indication and plan type. See section G below.

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:		Last Name:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	E-mail:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:	State:	ZIP:	
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider E-mail:		Office Contact Name:		Phone:	

Specialty *(Check one)*: ☐ **Dermatologist** ☐ **Gastroenterologist** ☐ **Rheumatologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other _____
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

E. PRODUCT INFORMATION

Request is for: Avsola (infliximab-axxq)
Dose: _____ **Frequency:** _____ **HCPCS Code:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For Initiation Requests (clinical documentation required for all requests):

Note: Avsola is non-preferred. The preferred products for MA plans are Entyvio, Inflectra, Remicade, Simponi Aria, and unbranded infliximab. For MAPD plans, Inflectra, Entyvio, Remicade, and unbranded infliximab are preferred for ulcerative colitis and Enbrel, Humira, Kevzara, Otezla, Rinvoq, Skyrizi, Stelara and Xeljanz/Xeljanz XR are preferred for other indications. Preferred products vary based on indication.

☐ Yes ☐ No Has the patient had prior therapy with Avsola (infliximab-axxq) within the last 365 days?

☐ Yes ☐ No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply)
☐ Entyvio (vedolizumab) ☐ Inflectra (infliximab-dyyb) ☐ Remicade (infliximab) ☐ Simponi Aria (golimumab) ☐ Unbranded infliximab

☐ Yes ☐ No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply)
☐ Enbrel (etanercept) ☐ Humira (adalimumab) ☐ Kevzara (sarilumab) ☐ Otezla (apremilast) ☐ Rinvoq (upadacitinib)
☐ Skyrizi (risankizumab-rzaa) ☐ Stelara (ustekinumab) ☐ Xeljanz/Xeljanz XR (tofacitinib)

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all the apply)
☐ Entyvio (vedolizumab) ☐ Inflectra (infliximab-dyyb) ☐ Remicade (infliximab) ☐ Simponi Aria (golimumab) ☐ Unbranded infliximab

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all the apply)

☐ Enbrel (etanercept) ☐ Humira (adalimumab) ☐ Kevzara (sarilumab) ☐ Otezla (apremilast) ☐ Rinvoq (upadacitinib)
☐ Skyrizi (risankizumab-rzaa) ☐ Stelara (ustekinumab) ☐ Xeljanz/Xeljanz XR (tofacitinib)

For All Requests (clinical documentation required for all requests):

☐ Yes ☐ No Will the requested drug be used in combination with any other biologic or targeted synthetic disease-modifying anti-rheumatic drug (DMARD) (e.g., Olumiant, Xeljanz)?

☐ Yes ☐ No Has the patient received a biologic or targeted synthetic DMARD (e.g., Rinvoq, Xeljanz) in the past?

→ ☐ Yes ☐ No Has the patient been tested for TB with a PPD test, interferon-release assay (IGRA) or chest x-ray within 6 months of initiating a biologic therapy?

→ (Check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray
Please enter the results of the TB test: ☐ positive ☐ negative ☐ unknown
If positive, Does the patient have latent or active TB? ☐ latent ☐ active ☐ unknown
If latent TB, ☐ Yes ☐ No Has treatment for latent tuberculosis (TB) infection been initiated or completed?
→ Please select: ☐ treatment initiated ☐ treatment completed

→ ☐ Yes ☐ No Does the patient have risk factors for TB?

→ ☐ Yes ☐ No Has the patient been tested for tuberculosis (TB) within the previous 12 months?
→ (Check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray
Please enter the results of the TB test: ☐ positive ☐ negative ☐ unknown
If positive, Does the patient have latent or active TB? ☐ latent ☐ active ☐ unknown
If latent TB, ☐ Yes ☐ No Has treatment for latent tuberculosis (TB) infection been initiated or completed?
→ Please select: ☐ treatment initiated ☐ treatment completed

For Initiation Requests:

Ankylosing spondylitis or axial spondyloarthritis

Please select which of the following applies to the patient: ☐ Active ankylosing spondylitis (AS) ☐ Active axial spondyloarthritis

☐ Yes ☐ No Has the patient previously received a biologic indicated for active ankylosing spondylitis?

→ ☐ Yes ☐ No Has the patient experienced an inadequate response with at least TWO nonsteroidal anti-inflammatory drugs (NSAIDs), or has an intolerance or contraindication to at least two NSAIDs?

Behçet's syndrome

☐ Yes ☐ No Has the patient received Otezla or a biologic indicated for the treatment of Behçet's disease?

→ ☐ Yes ☐ No Has the patient had an inadequate response to at least one nonbiologic medication for Behçet's disease (e.g., colchicine, systemic glucocorticoids, azathioprine)?

Crohn's disease

☐ Yes ☐ No Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)?

→ ☐ Yes ☐ No Does the patient have fistulizing Crohn's disease?

→ ☐ Yes ☐ No Has the patient previously received a biologic indicated for moderately to severely active Crohn's disease?

→ ☐ Yes ☐ No Has the patient tried and had an inadequate response to at least one conventional therapy option?

→ ☐ Yes ☐ No Does the patient have a contraindication or intolerance to at least one conventional therapy option (e.g.,azathioprine [Azasan, Imuran], budesonide [Entocort EC], ciprofloxacin [Cipro], mercaptopurine [Purinethol], methylprednisolone [Solu-Medrol], methotrexate, metronidazole [Flagyl], prednisone, sulfasalazine [Azulfidine, Sulfazine], rifaximin [Xifaxan], tacrolimus)?

→ Please select: ☐ Sulfasalazine (Azulfidine, Sulfazine) ☐ Metronidazole (Flagyl) ☐ Ciprofloxacin (Cipro) ☐ Prednisone ☐ Budesonide (Entocort EC) ☐ Azathioprine (Azasan, Imuran) ☐ Mercaptopurine (Purinethol) ☐ Methotrexate ☐ Methylprednisolone (Solu-Medrol) ☐ Rifaximin (Xifaxan) ☐ Tacrolimus

Granulomatosis with polyangiitis (Wegener's granulomatosis)

☐ Yes ☐ No Has the patient experienced an inadequate response with corticosteroids or immunosuppressive therapy (e.g., cyclophosphamide, azathioprine, methotrexate, or mycophenolate mofetil)?

→ ☐ Yes ☐ No Has the patient experienced an intolerance to corticosteroids and immunosuppressive therapy (e.g., cyclophosphamide, azathioprine, methotrexate, or mycophenolate mofetil)?

→ ☐ Yes ☐ No Does the patient have a contraindication to corticosteroids and immunosuppressive therapy (e.g., cyclophosphamide, azathioprine, methotrexate, or mycophenolate mofetil)?

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Hidradenitis suppurativa

☐ Yes ☐ No Has the patient been diagnosed with severe, refractory hidradenitis suppurativa?

☐ Yes ☐ No Has the patient previously received a biologic medication indicated for the treatment of severe, refractory hidradenitis suppurativa?

→ ☐ Yes ☐ No Has the patient experienced an inadequate response after at least 90 days of treatment with oral antibiotics?

→ ☐ Yes ☐ No Has the patient experienced an intolerable adverse effect to oral antibiotics?

→ ☐ Yes ☐ No Does the patient have a contraindication to oral antibiotics?

Juvenile idiopathic arthritis

☐ Yes ☐ No Has the patient previously received a biologic indicated for juvenile idiopathic arthritis?

→ ☐ Yes ☐ No Has the patient experienced an inadequate response to ANY of the following?

→ Please select: ☐ At least 1-month trial of NSAIDs ☐ At least 2 weeks of treatment with corticosteroids (e.g., prednisone, methylprednisolone) ☐ At least 3 months of treatment with methotrexate ☐ At least 3 months of treatment with leflunomide

Immune checkpoint inhibitor toxicity

☐ Yes ☐ No Has the patient experienced an inadequate response to corticosteroids?

→ ☐ Yes ☐ No Does the patient have cardiac toxicity?

Plaque psoriasis

☐ Yes ☐ No Has the patient been diagnosed with chronic, severe plaque psoriasis?

☐ Yes ☐ No Has the patient previously received Otezla or any other biologic medication indicated for the treatment of chronic, severe plaque psoriasis?

→ What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)?

Please select: ☐ Less than 3% of BSA

→ ☐ Yes ☐ No Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected?

☐ Greater than or equal to 3% of BSA

☐ Yes ☐ No 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?

→ ☐ Yes ☐ No Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine and acitretin?

→ ☐ Yes ☐ No Does the patient have severe psoriasis that warrants a biologic DMARD as first-line therapy (i.e. at least 10% of the body surface area (BSA) or crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected)?

→ Please indicate clinical reason to avoid pharmacologic treatment: ☐ Alcoholism, alcoholic liver disease or other chronic liver disease ☐ Breastfeeding ☐ Cannot be used due to risk of treatment-related toxicity ☐ Drug interaction with traditional systemic agent ☐ Pregnancy or planning pregnancy ☐ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension)

☐ Other reason to avoid pharmacologic treatment

→ ☐ Yes ☐ No Does the patient have severe psoriasis that warrants a biologic DMARD as first-line therapy (i.e. at least 10% of the body surface area (BSA) or crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected)?

Psoriatic arthritis

☐ Yes ☐ No Has the patient been diagnosed with active psoriatic arthritis (PsA)?

Pyoderma gangrenosum

☐ Yes ☐ No Has the patient previously received a biologic medication indicated for the treatment of pyoderma gangrenosum?

→ ☐ Yes ☐ No Has the patient experienced an inadequate response with corticosteroids or immunosuppressive therapy (e.g., cyclosporine or mycophenolate mofetil)?

→ ☐ Yes ☐ No Has the patient experienced an intolerance to corticosteroids and immunosuppressive therapy (e.g., cyclosporine or mycophenolate mofetil)?

→ ☐ Yes ☐ No Does the patient have a contraindication to corticosteroids and immunosuppressive therapy (e.g., cyclosporine mycophenolate mofetil)?

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Reactive arthritis

☐ Yes ☐ No Has the patient previously received a biologic medication indicated for the treatment of reactive arthritis?
- ☐ Yes ☐ No Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate titrated 20 mg per week?
  - ☐ Yes ☐ No Has the patient experienced intolerance to methotrexate?
    - ☐ Yes ☐ No Does the patient have a contraindication to methotrexate?
      - Please indicate the contraindication: ☐ History of intolerance or adverse event ☐ Alcoholism, alcoholic liver disease or other chronic liver disease ☐ Elevated liver transaminases ☐ Interstitial pneumonitis or clinically significant pulmonary fibrosis ☐ Renal impairment ☐ Pregnancy or planning pregnancy ☐ Breastfeeding ☐ Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia) ☐ Myelodysplasia ☐ Hypersensitivity ☐ Significant drug interaction ☐ Other

Rheumatoid arthritis

☐ Yes ☐ No Has the patient been diagnosed with moderately to severely active rheumatoid arthritis (RA)?

☐ Yes ☐ No Has the patient previously received a biologic or targeted synthetic disease modifying drug (e.g., Xeljanz) indicated for moderately to severely active rheumatoid arthritis?
- ☐ Yes ☐ No Is the requested medication being prescribed in combination with methotrexate or leflunomide?
  - Please indicate a clinical reason for the patient to not use methotrexate or leflunomide: ☐ History of intolerance or adverse event ☐ Alcoholism, alcoholic liver disease or other chronic liver disease ☐ Elevated liver transaminases ☐ Interstitial pneumonitis or clinically significant pulmonary fibrosis ☐ Renal impairment ☐ Pregnancy or planning pregnancy ☐ Breastfeeding ☐ Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia) ☐ Myelodysplasia ☐ Hypersensitivity ☐ Significant drug interaction
  - ☐ Yes ☐ No Does the patient have other reason or no clinical reason not to use methotrexate or leflunomide?
    - Please explain: _____
  - ☐ Yes ☐ No Has the patient experienced an inadequate response after at least 3 months of treatment with the methotrexate dose greater than or equal to 20 mg per week?
    - ☐ Yes ☐ No Has the patient experienced intolerance to methotrexate?
      - ☐ Yes ☐ No Does the patient have a contraindication to methotrexate?
        - Please indicate the contraindication: ☐ History of intolerance or adverse event ☐ Alcoholism, alcoholic liver disease or other chronic liver disease ☐ Elevated liver transaminases ☐ Interstitial pneumonitis or clinically significant pulmonary fibrosis ☐ Renal impairment ☐ Pregnancy or planning pregnancy ☐ Breastfeeding ☐ Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia) ☐ Myelodysplasia ☐ Hypersensitivity ☐ Significant drug interaction ☐ Other ☐ No clinical reason not to use methotrexate or leflunomide
- ☐ Yes ☐ No Is the requested medication being prescribed in combination with methotrexate or leflunomide?
  - Please indicate a clinical reason for the patient to not use methotrexate or leflunomide: ☐ History of intolerance or adverse event ☐ Alcoholism, alcoholic liver disease or other chronic liver disease ☐ Elevated liver transaminases ☐ Interstitial pneumonitis or clinically significant pulmonary fibrosis ☐ Renal impairment ☐ Pregnancy or planning pregnancy ☐ Breastfeeding ☐ Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia) ☐ Myelodysplasia ☐ Hypersensitivity ☐ Significant drug interaction ☐ Other ☐ No clinical reason not to use methotrexate or leflunomide

Sarcoidosis

☐ Yes ☐ No Has the patient experienced an inadequate response with corticosteroids or immunosuppressive therapy?
- ☐ Yes ☐ No Has the patient experienced an intolerance to corticosteroids and immunosuppressive therapy?
  - ☐ Yes ☐ No Does the patient have a contraindication to corticosteroids and immunosuppressive therapy?

Takayasu's arteritis

☐ Yes ☐ No Has the patient experienced an inadequate response with corticosteroids or immunosuppressive therapy (e.g., methotrexate, azathioprine, or mycophenolate mofetil)?
- ☐ Yes ☐ No Has the patient experienced an intolerance to corticosteroids and immunosuppressive therapy (e.g., methotrexate, azathioprine, or mycophenolate mofetil)?
  - ☐ Yes ☐ No Does the patient have a contraindication to corticosteroids and immunosuppressive therapy (e.g., methotrexate, azathioprine, or mycophenolate mofetil)?

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Ulcerative colitis

☐ Yes ☐ No Has the patient been diagnosed with moderately to severely active ulcerative colitis (UC)?

- ☐ Yes ☐ No Has the patient been hospitalized for fulminant ulcerative colitis (e.g., continuous bleeding, severe toxic symptoms, including fever and anorexia)?
- ☐ Yes ☐ No Has the patient previously received a biologic or targeted synthetic disease modifying drug (e.g., Xeljanz) indicated for moderately to severely active ulcerative colitis?
  - ☐ Yes ☐ No Has the patient tried and had an inadequate response to at least one conventional therapy option?
    - ☐ Yes ☐ No Does the patient have a contraindication or intolerance to at least one conventional therapy option (e.g., azathioprine [Azasan, Imuran], corticosteroid [e.g., budesonide, hydrocortisone [Entocort, Uceris], methylprednisolone, prednisone, cyclosporine [Sandimmune], mesalamine [Asacol, Lialda, Pentasa, Canasa, Rowasa], mercaptopurine [Purinethol], sulfasalazine, tacrolimus [Prograf], metronidazole/ciprofloxacin [for pouchitis only])?
  - Please select: ☐ Azathioprine (Azasan, Imuran) ☐ Corticosteroid (e.g., budesonide [Entocort, Uceris], hydrocortisone [Cortifoam, Colocort, Solu-Cortef, Cortef], methylprednisolone [Medrol, Solu-Medrol], prednisone) ☐ Cyclosporine (Sandimmune) ☐ Mesalamine (e.g., Apriso, Asacol, Lialda, Pentas, Canasa, Rowasa) ☐ Mercaptopurine (Purinethol) ☐ Sulfasalazine ☐ Tacrolimus (Prograf) ☐ Metronidazole (Flagyl) or Ciprofloxacin (Cipro) (for pouchitis only)

Uveitis

☐ Yes ☐ No Has the patient previously received a biologic medication indicated for the treatment of uveitis?

- ☐ Yes ☐ No Has the patient experienced an inadequate response with corticosteroids or immunosuppressive therapy (e.g., methotrexate, azathioprine, or mycophenolate mofetil)?
  - ☐ Yes ☐ No Has the patient experienced an intolerance to corticosteroids and immunosuppressive therapy (e.g., methotrexate, azathioprine, or mycophenolate mofetil)?
    - ☐ Yes ☐ No Does the patient have a contraindication to corticosteroids and immunosuppressive therapy (e.g., methotrexate, azathioprine, or mycophenolate mofetil)?

For Continuation Requests:

☐ Yes ☐ No Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

☐ Yes ☐ No Has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms since starting treatment with the requested drug?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required)*: _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.