

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:

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Enrollee First Name:

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Date of Birth (MM/DD/YYYY):

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

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Address:

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City, Town or Post Office:

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State:

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ZIP Code:

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Prescriber Information

Prescriber Last Name:

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Prescriber First Name:

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National Provider Identifier (NPI) Number:

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Preferred Contact (Telephone Number)

			-				-				
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Enrollee Last Name:

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Enrollee First Name:

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Clinical Criteria – Drug Information

Drug Administration:

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

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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):

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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)