Washington State Health Care Authority

Infliximab Injection Request

Please Fax Response to: 1-866-668-1214

Please Print. Please provide the information below. PRINT your answers, **attach supporting documentation**, sign, date, and return to our office as soon as possible to expedite this request.

Without this information, the request may be denied in 30 days.

Date of request	Client name	ProviderOne client ID
Prescriber's name		Billing provider NPI number
Telephone number	FAX number	Drug/strength/dose (Procedure/HCPC Code: J1745)

Request for: ☐ Remicade ☐ Inflectra Other:

Indicate patient's diagnosis

For the following diagnoses patient must have tried and failed **Humira:**

☐ Crohn's disease ☐ Ulcerative colitis

For the following diagnoses patient must have tried and failed **Humira and Enbrel:**

☐ Rheumatoid arthritis (RA) ☐ Ankylosing spondylitis
☐ Psoriatic arthritis ☐ Plaque psoriasis

☐ Other: _____ **Must provide justification for off-label use.**

Please indicate what your patient has tried and failed (check all that apply):

☐ Actemra (tocilizumab)	☐ Cimzia (certolizumab pegol)	☐ Cosentyx (secukinumab)
☐ Enbrel/Sureclick (etanercept)	☐ Entyvio (vedolizumab)	☐ Humira/Pen (adalimumab)
☐ Ilaris (canakinumab)	☐ Inflectra (infliximab-dyyb)	☐ Kineret (anakinra)
☐ Orencia/Clickjet (abatacept)	☐ Otezla (apremilast)	☐ Remicade (infliximab)
☐ Rituxan (rituximab)	☐ Simponi (golimumab)	☐ Stelara/IV (ustekinumab)
☐ Taltz (ixekizumab)	☐ Xeljanz/XR (tofacitinib citrate)	☐ Other: _____

What were the results of the trial(s)?

If patient has not tried and failed per the requirements above based on diagnosis, please explain why not:

Patient's weight in kilograms (kg): Pounds (lb): Date weight was taken:

Results of the most recent annual TB test: Date taken:

FDA approved dosing:

- Crohn's disease:
  - Maximum dose of 10mg/kg given every 8 weeks.
- Ulcerative colitis:
  - Maximum dose of 5mg/kg given at weeks 2 and weeks 6 of therapy and 5mg/kg given every 8 weeks after the induction regimen.
- Rheumatoid arthritis (RA):
  - Maximum dose of 10mg/kg given every 4 weeks.
- Ankylosing spondylitis:
  - Maximum dose of 5mg/kg given at week 2 and week 6 of therapy and 5mg/kg given every 8 weeks after the induction regimen.
- Psoriatic arthritis and Plaque psoriasis:
  - Maximum dose of 5mg/kg given at weeks 2 and weeks 6 of therapy and 5mg/kg given every 8 weeks after the induction regimen.

Is patient within the FDA approved dosing as per above? ☐ Yes ☐ No

Please provide dosing schedule:

☐ New start: Dose: Frequency:

☐ Continuation: Dose: Frequency: Date of last dose:

If over maximum dosing, must provide justification and documentation for off-label dosing.

Prescriber signature	Prescriber specialty	Date

A typed and completed *General Authorization for Information* form (13-835) must be attached to your request.

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