145 The West Mall, P.O. Box 110 U
Toronto, ON M8Z 5M4

PRIOR AUTHORIZATION PROGRAM FORM

Inflectra® (Infliximab)

Instructions:

1. Section 1 to be completed by Plan Member / Patient
2. Section 2 to be completed by Physician (expenses incurred by the completion of this form is at plan member's expense)
3. Section 3 to be completed by Pharmacist

Please fax completed form to NexgenRx Formulary Management to 1-877-639-4369 or mail to 145 The West Mall P.O. Box 110 U, Toronto, Ontario,M8Z-5M4

Section 1: To be completed by Patient

Member's Name: (Last , First)	Card ID Number:																			
Patient's Name: (Last, First)	Patient's Date of Birth (dd/mm/yy)	Relationship to Member (please circle) Employee Spouse Dependent	PATIENT CODE		
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Results of this request to be communicated to:

☐ Pharmacy	☐ Patient / Legal Guardian Named Below	☐ email:

I authorize NexgenRx Inc. (a) to use the personal information disclosed on this form, and any other personal information known to NexgenRx Inc. regarding the above-named patient, for the purpose of assessing this prior authorization request and any related claim and administering the benefit plan under which any such claim is made, and (b) to contact, and to obtain any such personal information from and to disclose any such personal information to, any physician, pharmacist or other health care professional having knowledge of such patient's health relevant to this request and any related claim.

Patient / Legal Guardian Name: _____ Telephone Number: _____

Signature of Patient/ Legal Guardian: _____ Date (dd/mm/yy):_____

Section 2: To be completed by Physician

Drug Name & Strength: **Inflectra 100mg vial**	DIN: **02419475**	**Dosage Instructions:**

Eligibility for drug coverage is dependent upon the patient meeting at least one of the qualifying criteria listed below. If the patient has another drug plan, prior authorization may cover some or all of the excess not paid by the primary plan.

Please indicate if the patient meets at least one of the following qualifying criteria for drug coverage:

□ Use in combination with methotrexate for the reduction in signs and symptoms, inhibition of the progression of structural damage and improvement in physical function in adult patients with moderately to severely active rheumatoid arthritis.

□ Reduction of signs and symptoms and improvement in physical function in patients with active ankylosing spondylitis who have responded inadequately, or are intolerant to, conventional therapies.

□ Reduction of signs and symptoms, induction and maintenance of clinical remission and mucosal healing and reduction of corticosteroid use in adult patients with moderately to severely active Crohn's disease who have had an inadequate response to a corticosteroid and/or aminosalicylate. Inflectra can be used alone or in combination with conventional therapy.

□ Treatment of fistulising Crohn's disease, in adult patients who have not responded despite a full and adequate course of therapy with conventional treatment.

□ Reduction of signs and symptoms, induction and maintenance of clinical remission and mucosal healing, and reduction or elimination of corticosteroid use in adult patients with moderately to severely active ulcerative colitis who have had an inadequate response to conventional therapy (i.e., aminosalicylate and/or corticosteroid and/or an immunosuppressant).

□ Reduction of signs and symptoms, induction of major clinical response, and inhibition of the progression of structural damage of active arthritis, and improvement in physical function in patients with psoriatic arthritis.

□ Treatment of adult patients with chronic moderate to severe plaque psoriasis who are candidates for systemic therapy. For patients with chronic moderate plaque psoriasis, Inflectra should be used after phototherapy has been shown to be ineffective or inappropriate. When assessing the severity of psoriasis, the physician should consider the extent of involvement, location of lesions, response to previous treatments, and impact of disease on the patient's quality of life.

Physician Name: (Last, First)	License Number:
Address: (Street, City, Province, Postal Code)	Telephone Number : ( ) - Fax Number: ( ) -
Signature of Physician:	Date (dd/mm/yy)

Section 3: To be completed by Pharmacist

Pharmacy Name:	Provider Number:
Pharmacy Address: (Street, City, Province, Postal Code)	Telephone Number : ( ) - Fax Number: ( ) -
Signature of Pharmacist: _____ Pharmacist's Name: (Print Last, First)	

Internal Office Use Only:

Date Received:			Date & Approved by: