US Family Health Plan

Prior Authorization Request Form for

Infliximab-dyyb SQ (Zymfentra)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Clinical documentation may be required for approval.
Prior authorization does not expire.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is the patient 18 years of age or older?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Does the patient have moderate to severely active ulcerative colitis?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Humira is the Department of Defense's preferred targeted biologic agent for ulcerative colitis. Has the patient tried Humira?	☐ Yes Proceed to question **4**	☐ No Proceed to question **6**
4. Has the patient had an inadequate response to Humira?	☐ Yes Proceed to question **7**	☐ No Proceed to question **5**
5. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
6. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Has the patient had an inadequate response to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [such as, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [for example, azathioprine], etc.)	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**

8. Does the patient have evidence of a negative TB test result in the past 12 months (or TB is adequately managed)?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Will the patient be receiving any other targeted immunomodulatory biologics with mirikizumab including but not limited to the following: certolizumab (Cimzia), etanercept (Enbrel), golimumab (Simponi), infliximab (Remicade), apremilast (Otezla), ustekinumab (Stelara), abatacept (Orencia), anakinra (Kineret), tocilizumab (Actemra), tofacitinib (Xeljanz/Xeljanz XR), rituximab (Rituxan), secukinumab (Cosentyx), ixekizumab (Taltz), brodalumab (Siliq), sarilumab (Kevzara), guselkumab (Tremfya), baricitinib (Olumiant), tildrakizumab (Ilumya), risankizumab (Skyrizi), upadacitinib (Rinvoq ER), or vedolizumab (Entyvio)?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

STEP 3 **I certify the above is true to the best of my knowledge.** Please sign and date.

Prescriber Signature _____ Date _____