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Cimzia (certolizumab pegol) Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004

Provider Help Desk 1-800-454-3730

1. Patient information

2. Physician information

Patient name: _____ Patient ID #: _____ Patient DOB: _____ Date of Rx: _____ Patient phone #: _____ Patient email address: _____	Prescribing physician: _____ Physician address: _____ Physician phone #: _____ Physician fax #: _____ Physician specialty: _____ Physician DEA: _____ Physician NPI #: _____ Physician email address: _____
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3. Medication

4. Strength

5. Directions

6. Quantity per 30 days

Cimzia (certolizumab pegol)	_____	_____	Specify: _____
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7. Diagnosis: _____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Required for All Requests:

- Yes No Patient has been screened for hepatitis B and C [PLEASE NOTE: patients with active hepatitis B will not be considered for coverage] Patients with evidence of active Hepatitis B infection (Hepatitis surface antigen positive > 6 months) must have documentation they are receiving or have received effective antiviral treatment
- Yes No Patient has been treated for solid malignancies, non-melanoma skin cancer, or lymphoproliferative malignancy within the last 5 years of starting or resuming treatment with a biological agent [PLEASE NOTE: Biological agents include: Abatacept (Orencia); Adalimumab (Humira); Anakinra (Kineret); Certolizumab Pegol (Cimzia); Etanercept (Enbrel); Infliximab (Remicade); Golimumab (Simponi); Tocilizumab (Actemra); Ustekinumab (Stelara); Secukinumab (Cosentyx)]
- Yes No Patient has a diagnosis of congestive heart failure (CHF) that is New York Heart Association (NYHA) class III or IV and with an ejection fraction of 50% or less
- Yes No Patient has been screened for latent TB infection [PLEASE NOTE: patients with latent TB will only be considered after one month of TB treatment and patients with active TB will only be considered upon

- completion of TB Treatment]
- Yes No The requested medication will be given concurrently with live vaccines
 - Yes No Patient has had previous trials and therapy failures with TWO preferred biological agents (the preferred biological agents are: Humira, Enbrel, Cosentyx)
- * DOCUMENTATION must be submitted which includes the following information:** that the patient had previous trials and therapy failures with two preferred biologicals. Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data

Rheumatoid Arthritis (RA):

- Yes No Patient has a diagnosis of rheumatoid arthritis (RA)
 - Yes No Patient had a trial, and inadequate response to, TWO preferred disease modifying anti-rheumatic drugs (DMARDs) used concurrently. [PLEASE NOTE: The combination must include methotrexate plus another preferred oral DMARD (hydroxychloroquine, sulfasalazine, or leflunomide)]
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- *DOCUMENTATION must be submitted which includes the following information:** that there is clinical evidence that the use of methotrexate and/or the preferred medications would be medically contraindicated for this patient. [PLEASE NOTE: The preferred DMARDs are hydroxychloroquine, sulfasalazine and leflunomide. Documentation may include but is not limited to, chart notes, prescriptions claims records, prescription receipts, and laboratory data.
- Yes No Patient had a clinical evidence that the use of methotrexate and/or the preferred medications would be medically contraindicated for this patient. [PLEASE NOTE: The preferred DMARDs are hydroxychloroquine, sulfasalazine, leflunomide, and minocycline]
 - Yes No Patient had an unsuccessful methotrexate trial
 - Yes No There evidence of severe disease documented by radiographic erosions

Moderate to Severe Psoriatic Arthritis:

- Yes No Patient has a diagnosis of moderate to severe psoriatic arthritis
 - Yes No Patient had a trial and inadequate response to the preferred oral DMARD
 - Yes No Patient have a contraindication to the use of methotrexate
 - Yes No Patient had a trial of leflunomide or sulfasalazine
- * DOCUMENTATION must be submitted which includes the following information:** that there is a clinical evidence that the use of the preferred oral DMARD, methotrexate would be medically contraindicated for this patient, AND if there is a contraindication to methotrexate then also the clinical reason this patient would not be able to use leflunomide or sulfasalazine instead. Documentation may include but is not limited to, chart notes, prescriptions claims records, prescription receipts, and laboratory data

Moderate to Severe Juvenile Idiopathic Arthritis:

- Yes No Patient has a diagnosis of moderate to severe juvenile idiopathic arthritis
 - Yes No Patient has had a trial, and inadequate response to, intraarticular glucocorticoid injections and the preferred oral DMARD, methotrexate
 - Yes No Patient have a contraindication to the use of methotrexate
 - Yes No Patient had a trial of leflunomide or sulfasalazine
- * DOCUMENTATION must be submitted which includes the following information:** that there is a clinical evidence that the use of the preferred oral DMARD, methotrexate would be medically contraindicated for this patient, AND if there is a contraindication to methotrexate then also the clinical reason this patient would not be able to use leflunomide or sulfasalazine instead. Documentation may include but is not limited to, chart notes, prescriptions claims records, prescription receipts, and laboratory data

Ankylosing Spondylitis:

- Yes No Patient has a diagnosis of ankylosing spondylitis
- Yes No * **DOCUMENTATION must be submitted which includes the following information:** Patient had an inadequate response to at least two preferred non-steroidal anti-inflammatories (NSAIDs) at maximum therapeutic doses (trials should be at least three months in duration) [PLEASE NOTE: Preferred NSAIDs are: diclofenac potassium, diclofenac sodium, etodolac tab 400 mg, etodolac tab 500 mg, flurbiprofen, Ibuprofen Susp 100 MG/5ML, Ibuprofen tab 200 MG, ibuprofen tab 400 mg, ibuprofen tab 600 mg, ibuprofen tab 800 mg, indomethacin, ketoprofen, NAPROSYN SUSP, naproxen, naproxen sodium tab 550 mg, sulindac.
- Yes No Patient has adverse responses or contraindications to NSAID use
* **DOCUMENTATION must be submitted which includes the following information:** that there is a clinical evidence that the use of the preferred non-steroidal anti-inflammatories (NSAIDs) at maximum therapeutic doses would be medically contraindicated for this patient. Documentation may include but is not limited to, chart notes, prescriptions claims records, prescription receipts, and laboratory data.
- Yes No Patient has symptoms of peripheral arthritis
- Yes No Patient failed a 30-day treatment trial with at least one conventional disease modifying anti-rheumatic drug (DMARD) [PLEASE NOTE: DMARDs include sulfasalazine and methotrexate]
- Yes No Patient has adverse responses or contraindication to DMARD use
* **DOCUMENTATION must be submitted which includes the following information:** that there is a clinical evidence that the use of the preferred DMARD would be medically contraindicated for this patient. Documentation may include but is not limited to, chart notes, prescriptions claims records, prescription receipts, and laboratory data.

Crohn's disease:

- Yes No Patient has a diagnosis of Crohn's disease
- Yes No Patient had a trial, and inadequate response to TWO preferred conventional therapy including aminosalicylates (mesalamine, sulfasalazine), azathioprine/6-mercaptopurine, AND/OR methotrexate
* **DOCUMENTATION must be submitted which includes the following information:** that there is a clinical evidence that the use of the preferred conventional therapy including aminosalicylates (mesalamine, sulfasalazine), azathioprine/6-mercaptopurine, AND/OR methotrexate would be medically contraindicated for this patient. Documentation may include but is not limited to, chart notes, prescriptions claims records, prescription receipts, and laboratory data.

Moderate to Severe Ulcerative colitis:

- Yes No Patient has a diagnosis of moderate to severe ulcerative colitis
- Yes No Patient had a trial, and inadequate response to TWO preferred conventional therapy including aminosalicylates (mesalamine, sulfasalazine), azathioprine/6-mercaptopurine
* **DOCUMENTATION must be submitted which includes the following information:** that there is a clinical evidence that the use of the preferred conventional therapy including aminosalicylates (mesalamine, sulfasalazine), azathioprine/6-mercaptopurine, would be medically contraindicated for this patient. Documentation may include but is not limited to, chart notes, prescriptions claims records, prescription receipts, and laboratory data.

9. Physician signature

Prescriber or authorized signature

Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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