Cimzia (certolizumab pegol)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION		
LAST NAME:	**FIRST NAME:**	
PHONE NUMBER:	**DATE OF BIRTH:**	
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
PATIENT INSURANCE ID NUMBER:		

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION		
LAST NAME:	**FIRST NAME:**	
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**	
NPI NUMBER:	**DEA NUMBER:**	
PHONE NUMBER:	**FAX NUMBER:**	
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
REQUESTER (if different than prescriber):	**OFFICE CONTACT PERSON:**	

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ **YES** (if yes, complete below) ☐ **NO**		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ **Ankylosing spondylitis** ☐ **Moderate to severely active Crohn's disease** ☐ **Moderate to severe plaque psoriasis** ☐ **Moderate to severe active psoriatic arthritis** ☐ **Moderate to severely active rheumatoid arthritis** ☐ **Plaque Psoriasis** ☐ **Active non-radiological axial spondylarthritis** ☐ **Active polyarticular juvenile arthritis** ☐ **Other diagnosis:** _____ **ICD-10 Code(s):**	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Is patient going to be using drug in combination with a clinical trial? ☐ **Yes** ☐ **No**

Select if Cimzia is prescribed by one of the following specialist:
□ **Dermatologist** □ **Gastroenterologist** □ **Rheumatologist**

Will the patient use drug in combination with another biologic response modifier or immunomodulatory agent? ☐ **Yes** ☐ **No**

Has the patient tried and had an inadequate response to a three month trial of the biosimilar for Humira- adalimumab-aacf? ☐ **Yes** ☐ **No (Please submit documentation)**

Does patient have a absolute contraindication to the biosimilar for Humira- adalimumab-aacf? ☐ **Yes** ☐ **No (Please submit documentation)**

Has the patient tried and had an inadequate response to a trial of the biosimilar for Actemra, Tyenne(tocilizumab-aazg)? ☐ **Yes** ☐ **No (Please submit documentation)**

Does patient have a absolute contraindication to the biosimilar for Actemra, Tyenne(tocilizumab-aazg)? ☐ **Yes** ☐ **No (Please submit documentation)**

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For ankylosing spondylitis, also answer the following:

Has the patient had an adequate trial and failure of at least TWO non-steroidal anti-inflammatory agents (NSAIDs)? ☐ Yes ☐ No (Provide NSAIDs and dates of service)

Has the patient tried methotrexate? ☐ Yes ☐ No (Provide dates of service)

For moderate to severely active Crohn's disease, also answer the following:

Does the patient have documented trial and failure on oral immunosuppressive therapy (i.e., corticosteroids, methotrexate, azathioprine, and/or 6-mercaptopurine)? ☐ Yes ☐ No (Please submit documentation)

For moderate to severely active psoriatic arthritis, also answer the following:

Has the patient had at least a 3 month trial and failed previous therapy with an oral non-biologic disease modifying anti-rheumatic agent (DMARD) (e.g., methotrexate,sulfasalazine [Azulfidine], or leflunomide [Arava], or cyclosporine)? ☐ Yes ☐ No (Please submit documentation)

Does the patient have chronic liver disease such as chronic alcohol abuse/alcoholism, chronic hepatitis, fatty liver, nonalcoholic, steatohepatitis (NASH), or elevated liver enzymes? ☐ Yes ☐ No (Please submit documentation)

For moderate to severely active rheumatoid arthritis, also answer the following:

Has the patient had a trial with methotrexate or another oral non-biologic disease modifying anti-rheumatic agent (DMARD) such as Imuran, Ridaura, Arava, Plaquenil, or sulfasalazine? ☐ Yes ☐ No (Please submit documentation)

Does the patient have chronic liver disease such as chronic hepatitis, fatty liver, nonalcoholic steatohepatitis (NASH), or elevated liver enzymes)? ☐ Yes ☐ No (Please submit documentation)

Moderate to severe plaque Psoriasis:

Is the patient ≥18 years of age? ☐ Yes ☐ No

Does the patient have plaques covering ≥ 10% of their body surface area (BSA)? ☐ Yes ☐ No (Please submit documentation)

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Does patient have < 3% of BSA with involvement of palms, soles, head and neck, or genitalia which causes disruption of normal activities? ☐ **Yes** ☐ **No (Please submit documentation)**

Is topical therapy no longer tolerated or effective with agents such as corticosteroids, anthralin, calcipotriene, or Tazarotene for thepatient? ☐ **Yes** ☐ **No (Please submit documentation)**

Select if the patient has had previous treatment failure with the following Please submit documentation.

- ☐ **Phototherapy**
- ☐ **Psoralens with UVA light (PUVA)**
- ☐ **UVB with coal tar**

Has the patient had previous treatment failure with an oral systemic therapy (e.g., acitretin, methotrexate or cyclosporine)? ☐ **Yes** ☐ **No**

If "no" to the above question, does the patient have a contraindication to ALL oral systemic treatments?* ☐ **Yes** ☐ **No**

***Documentation of a contraindication to ALL oral systemic treatments must be submitted*.**

For Active non-radiological axial spondylarthritis:

Please submit chart notes corroborating patient has active non-radiological axial spondyloarthritis, AND a submitted radiology report documenting the absence of sacroiliitis on SI joint x-rays.

Has patient had active axial spondyloarthritis for at least 12 months? ☐ **Yes** ☐ **No**
(Please submit documentation)

Does patient have objective signs of inflammation indicated by C-reactive protein (CRP) levels above the upper limit of normal? ☐ **Yes** ☐ **No (Please submit lab report)**

Does patient have documented sacroiliitis on magnetic resonance imaging (MRI)? ☐ **Yes** ☐ **No (Please submit MRI report)**

Does patient have an intolerance to or an inadequate response to at least two NSAIDs?
☐ **Yes** ☐ **No (Please submit documentation)**

Does patient have fibromyalgia? ☐ **Yes** ☐ **No**

For active polyarticular juvenile arthritis:

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Has patient had a trial and failure with previous treatment with an oral disease modifying anti-rheumatic agents (DMARDs), such as methotrexate or sulfasalazine or leflunomide? ☐ **Yes** ☐ **No**
(Please submit documentation)

Reauthorization:

If this is a reauthorization request, answer the following questions:

Is the patient continuing to have a positive clinical response and remission of disease is maintained with continued use?* ☐ **Yes** ☐ **No**

***Must be confirmed by provided chart notes.**

Select if Cimzia is prescribed by one of the following specialist:

□ **Dermatologist**
□ **Gastroenterologist**
□ **Rheumatologist**

Will the patient use drug in combination with another biologic response modifier or immunomodulatory agent? ☐ **Yes** ☐ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 877-228-7909