

# Pharmacy Medical Necessity Form

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

 This form applies to:       Commercial Plan     Medicaid Plan     Medicare Plan

**Cimzia<sup>®</sup> (certolizumab)**       Urgent       Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

**Product:**

- Cimzia – injection, lyophilized powder for solution 200mg single use vial (administered by health professional)
- Cimzia – injection, solution 200mg prefilled syringe (patient self-administered)

Dose: \_\_\_\_\_ Start date: \_\_\_\_\_

**Place of administration:**

- Self-administered
- Provider's office
- Outpatient Infusion Center. Name of center: \_\_\_\_\_
- Home Infusion. Name of agency: \_\_\_\_\_

**Billing options:**

- Physician buy and bill
- Preferred Specialty Vendor
- Other: \_\_\_\_\_

## Priority Health Precertification Requirements:

**Authorization of Cimzia requires:**

- Documented therapeutic trial and clinical failure with either Enbrel or Humira
- One of the following diagnoses:
  1. Rheumatoid arthritis
    - Documented therapeutic trial of at least one DMARD
    - Documented therapeutic trial and clinical failure with either Enbrel or Humira
  2. Crohn's Disease
    - Documented therapeutic trial of at least two of the following formulary alternatives: corticosteroids, sulfasalazine, osalazine, and mesalamine
    - Documented therapeutic trial and clinical failure with Humira
- Negative TB test (must be done yearly)

**Continuation of Cimzia therapy requires:**

- Patient must be compliant taking the medication as prescribed
- Patient must be tolerating the medication

- Patient must not be experiencing any severe adverse reactions while taking the medication
- Patient must be responding positively to the medication
- Patient must have a negative TB test within the past 12 months

Diagnosis:

- Rheumatoid Arthritis
- Crohn's Disease
- Other: \_\_\_\_\_ Please provide rationale for use:  
\_\_\_\_\_

Will patient be self-injecting Cimzia?

- Yes – covered under pharmacy benefit, use prefilled syringe
- No – covered under medical benefit, use lypholized powder for solution

Results of annual (within the past 12 months) TB test:

- Positive - Rationale for use: \_\_\_\_\_
- Negative
- Test not done – Rationale for use: \_\_\_\_\_

New request or continuation of therapy:

- New (see section 1)
- Continuation (see section 2)

**Section 1 – New requests:**

**Rheumatoid Arthritis**

Patient has had a therapeutic trial of at least one of the following DMARDS:

- Yes
- No – Rationale for use: \_\_\_\_\_

	Dose	Dates	Outcome
<input type="checkbox"/> azathioprine	_____	_____	_____
<input type="checkbox"/> Cyclosporine	_____	_____	_____
<input type="checkbox"/> d-penicillamine	_____	_____	_____
<input type="checkbox"/> gold sodium thiomalate	_____	_____	_____
<input type="checkbox"/> auranofin	_____	_____	_____
<input type="checkbox"/> aurothioglucose	_____	_____	_____
<input type="checkbox"/> hydroxychloroquine	_____	_____	_____
<input type="checkbox"/> leflunomide	_____	_____	_____
<input type="checkbox"/> methotrexate	_____	_____	_____
<input type="checkbox"/> sulfasalazine	_____	_____	_____

Patient has had a therapeutic trial of Enbrel or Humira?

- Yes
- No – Rationale for use: \_\_\_\_\_

	Dose	Dates	Outcome
<input type="checkbox"/> Enbrel	_____	_____	_____
<input type="checkbox"/> Humira	_____	_____	_____

**Crohn's Disease**

 Patient has had a documented trial and clinical failure of at least **two** of the following:

Yes  
 No – Rationale for use: \_\_\_\_\_

	Dose	Dates	Outcome
<input type="checkbox"/> corticosteroid	_____	_____	_____
<input type="checkbox"/> sulfasalazine	_____	_____	_____
<input type="checkbox"/> olsalazine	_____	_____	_____
<input type="checkbox"/> mesalamine	_____	_____	_____

Patient has had a therapeutic trial of Humira?

Yes    Dose: \_\_\_\_\_    Date: \_\_\_\_\_    Outcome: \_\_\_\_\_  
 No – Rationale for use: \_\_\_\_\_

**Section 2 – Requests for continuation of therapy:**

- The patient is compliant in taking the medication as scheduled
- The patient tolerated the medication
- The patient did not experience any severe adverse reactions while taking the medication
- The patient has responded to treatment, as determined by the prescribing physician
- The patient has had a negative TB test result within the past 12 months-  
Date of test: \_\_\_\_\_

**Note: Approval, when granted, will be for a 30 day supply per fill at the dose and duration outlined below in Table 1.**

**Table 1: Dose and Duration of Authorization**

Indication	Initial Authorization	Continuation Authorization
Adult rheumatoid arthritis	<ul style="list-style-type: none"> <li>• Approved for 3 months</li> <li>• Approved dose is 400 mg (given as 2 subcutaneous injections of 200 mg) initially, and at weeks 2 and 4, followed by 200 mg every other week</li> </ul>	<ul style="list-style-type: none"> <li>• Approved for an additional 12 months if the patient has responded, as determined by the prescribing physician</li> <li>• Approved dose is 200 mg every 4 weeks</li> <li>• Up to 400mg (given as 2 subcutaneous injections of 200 mg) every 4 weeks can be considered</li> </ul>
Crohn's disease	<ul style="list-style-type: none"> <li>• Approved for 3 months</li> <li>• Approved dose is 400 mg (given as 2 subcutaneous injections of 200 mg) initially, and at weeks 2 and 4, followed by 400mg every 4 weeks</li> </ul>	<ul style="list-style-type: none"> <li>• Approve for an additional 12 months of therapy if the patient has responded, as determined by the prescribing physician</li> <li>• Approved dose is 400 mg (given as 2 subcutaneous injections of 200 mg) every 4 weeks</li> </ul>



\*\*\* All fields must be complete and legible for Prior Authorization Review\*\*\*

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**YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**