Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☐ **Medicare Part D**
This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Cimzia® (certolizumab)

Member

Last Name: _____ First Name: _____
ID #: _____ DOB: _____ Gender: _____
Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____
Provider Address: _____
Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Drug information

☐ New Request ☐ Continuation Request

Drug product:
☐ Cimzia 200 mg/mL prefilled syringe
☐ Cimzia 200 mg/mL starter kit
☐ Cimzia 400 mg powder for injection

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Dosing frequency: _____

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

Before this drug is covered, the patient must meet all of the following requirements:

1. Must be used for a medically-accepted indication*
   - For ankylosing spondylitis:
     i. Must have a BASDAI score of 4
     ii. Must have presence of active disease for at least 4 weeks
     iii. Must have documented trial with one NSAID
   - For Crohn's disease
     i. Must have a documented therapeutic trial and clinical failure with Humira
   - For psoriatic arthritis
     i. Must have a documented trial with either Enbrel or Humira
   - For rheumatoid arthritis
     i. Must have a documented therapeutic trial of at least one DMARD
     ii. Must have a documented therapeutic trial with either Enbrel or Humira

2. Must have a negative TB test in the last 12 months

Additional information

Note: When criteria are met, duration of approval will be 1 year

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 01/2019
Last reviewed 01/2019

Medically accepted indication*

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

Priority Health Precertification Documentation

A. What is the date and result of the patient's most recent TB test?

- ☐ Negative **Date:** _____
- ☐ Positive
- ☐ Not completed. **Are you requesting an exception to the criteria?**
  - ☐ Yes. ***Rationale for exception***: _____
  - ☐ No

B. What is the patient's condition?

- ☐ Ankylosing spondylitis
  1. **Does the patient have a BASDAI score of 4?**
     - ☐ Yes. BASDAI score: _____
     - ☐ No. **Are you requesting an exception to the criteria?**
       - ☐ Yes. ***Rationale for exception***: _____
       - ☐ No
  2. **Has the patient had presence of active disease for at least 4 weeks?**
     - ☐ Yes
     - ☐ No. **Are you requesting an exception to the criteria?**
       - ☐ Yes. ***Rationale for exception***: _____
       - ☐ No
  3. **Has the patient had a trial with one NSAID?**
     - ☐ Yes
     - ☐ No. **Are you requesting an exception to the criteria?**
       - ☐ Yes. ***Rationale for exception***: _____
       - ☐ No
- ☐ Crohn's disease
  1. **Did the patient first try and fail Humira?**
     - ☐ Yes.
     - ☐ No. **Are you requesting an exception to the criteria?**
       - ☐ Yes. ***Rationale for exception***: _____
       - ☐ No
- ☐ Psoriatic arthritis
  1. **Did the patient first try Enbrel or Humira?**
     - ☐ Yes.
     - ☐ No. **Are you requesting an exception to the criteria?**
       - ☐ Yes. ***Rationale for exception***: _____
       - ☐ No
- ☐ Rheumatoid arthritis
  1. **Has the patient had a trial with a DMARD?**
     - ☐ Yes.
     - ☐ No. **Are you requesting an exception to the criteria?**
       - ☐ Yes. ***Rationale for exception***: _____
       - ☐ No

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Last reviewed 01/2019

2. **Did the patient first try Enbrel or Humira?**
   - ☐ Yes.
   - ☐ No. **Are you requesting an exception to the criteria?**
     - ☐ Yes. ***Rationale for exception***: _____
     - ☐ No

☐ *Other – the patient's condition is:* _____
Rationale for Other use: _____

Priority Health Medicare Exception Request *(exceptions to the above criteria)*

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Cimzia likely be the most effective option for this patient?
☐ Yes ☐ No
If yes, please explain why: _____

_____

_____

If the patient is currently using Cimzia, would changing the patient's current regimen likely result in adverse effects for the patient?
☐ Yes ☐ No
If yes, please explain: _____

_____

_____

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Last reviewed 01/2019