PriorityHealth

Medical Prior Authorization Form

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

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)**
☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Cimzia® (certolizumab)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Physician: _____ Prov. Phone: _____ Prov. Fax: _____

Physician Address: _____

Physician NPI: _____ Contact Name: _____

Physician Signature: _____ Date: _____

Product and Billing Information

☐ New request ☐ Continuation request

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

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Date of next dose (if applicable): _____
Dose:_____ **Dose Frequency**:_____

Place of administration:
☐ Physician's office
☐ Outpatient infusion
Facility: _____ NPI:_____ Fax:_____
☐ Home infusion
Facility: _____ NPI:_____ Fax:_____

Billing:
☐ Physician to buy and bill
☐ Facility to buy and bill
☐ Specialty Pharmacy
Pharmacy:_____ NPI:_____ Fax:_____

ICD-10 Diagnosis code(s): _____

CIMZIA COVERAGE POLICY

- Before Cimzia is covered, the patient must meet all of the General Criteria for Cimzia and all of the Specific Criteria for the treatment diagnosis. If these criteria are not met, the prescriber must provide an explanation of why an exception to the criteria is necessary.
- Coverage for a diagnosis not listed below will be considered on a case by case basis. Please provide rationale for use and all pertinent patient information.
- Cimzia will not be covered in combination with another biologic drug.
- Please provide rationale when requesting any dose or dosing interval not listed in the FDA label.

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 09/2018
Last reviewed 01/2019

Criteria

General Criteria for ALL Diagnoses:

a) Patient has evidence of a negative TB test result in the past 12 months (or TB is adequately managed); AND
b) Patient does not have moderate to severe heart failure (or heart failure is adequately managed); AND
c) Prescriber is a specialist or has consulted with a specialist for the condition being treated.

Specific Criteria for Individual Diagnoses:

1. Ankylosing Spondylitis
   a) Patient has tried at least TWO of the following: Cosentyx, Enbrel, or Humira, each for a period of at least 3 months.

2. Crohn's Disease
   a) The patient has tried one other agent for Crohn's disease (e.g., corticosteroid, azathioprine, 6-mercaptopurine, methotrexate)
   b) Patient has tried Humira or Stelara for a period of at least 3 months.

3. Psoriatic Arthritis
   a) Patient has tried at least ONE conventional systemic DMARD (such as methotrexate, leflunomide, sulfasalazine, or azathioprine) for a period of at least 3 months, AND
   b) Patient has tried at least TWO of the following: Cosentyx, Enbrel, Humira, Xeljanz/XR, or Stelara, each for a period of at least 3 months.

4. Rheumatoid Arthritis
   a) Patient has tried at least ONE conventional systemic DMARD (such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine) for a period of at least 3 months; AND
   b) Patient has tried at least TWO of the following: Actemra, Enbrel, Humira, or Xeljanz/XR, each for a period of at least 3 months.

5. Plaque psoriasis
   a) Patient has tried **ALL** of the following for a period of at least 3 months:
      a. One topical agent
      b. One non-biologic systemic agent (e.g., methotrexate [MTX], cyclosporine, acitretin)
      c. Phototherapy
      d. TWO of Cosentyx, Humira, Otezla, or Stelara

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Ankylosing spondylitis
- ☐ Crohn's disease
- ☐ Psoriatic arthritis
- ☐ Rheumatoid arthritis
- ☐ Other – the patient's condition is: _____
  Rationale for use: _____

B. Which of the following has the patient had a documented therapeutic trial with?

- ☐ Methotrexate Dates of therapy: _____
- ☐ Leflunomide Dates of therapy: _____
- ☐ Hydroxychloroquine Dates of therapy: _____
- ☐ Sulfasalazine Dates of therapy: _____

All fields must be complete and legible for review. Your office will receive a response via fax.
Updated 09/2018
Last reviewed 01/2019

☐ Cosentyx Dates of therapy: _____
☐ Azathioprine Dates of therapy: _____
☐ Enbrel Dates of therapy: _____
☐ Humira Dates of therapy: _____
☐ Stelara Dates of therapy: _____
☐ Xeljanz/XR Dates of therapy: _____
☐ Actemra Dates of therapy: _____
☐ Other Drug: _____ Dates of therapy: _____

C. Has the patient had a negative TB test result in the past 12 months?

☐ Yes Date: _____
☐ No, rationale for use: _____

D. Does the patient have moderate to severe heart failure?

☐ Yes Date: _____
☐ No, rationale for use: _____

E. Will the patient be receiving other biologic therapy in combination with Cimzia?

☐ No ☐ Yes, rationale for use: _____

The following questions are required for **plaque psoriasis** only:

F. Has the patient had a trial with one or more topical agents for a period of at least 3 months?

☐ Yes
☐ No – rationale for use: _____

G. Has the patient had a trial with phototherapy for a period of at least 3 months?

☐ Yes, UVA
☐ Yes, UVB
☐ No – rationale for use: _____

H. Has the patient had a trial with one or more non-biologic systemic agents for a period of at least 3 months?

☐ No – rationale for use: _____
☐ Yes – Please mark the agent(s) tried:
  ☐ Methotrexate Dates of therapy: _____
  ☐ Cyclosporine Dates of therapy: _____
  ☐ Acitretin Dates of therapy: _____
  ☐ Other Drug: _____ Dates of therapy: _____

I. Has the patient tried TWO of the following for at least 3 months each?

☐ No – rationale for use: _____
☐ Yes – Please mark the agent(s) tried:

  ☐ Cosentyx Dates of therapy: _____
  ☐ Humira Dates of therapy: _____
  ☐ Otezla Dates of therapy: _____
  ☐ Stelara Dates of therapy: _____

All fields must be complete and legible for review. Your office will receive a response via fax.
Updated 09/2018
Last reviewed 01/2019