PRIOR AUTHORIZATION REQUEST
Cimzia

PATIENT: Name______________________
Address: ______________________
City, State, Zip_____________________
D.O.B. _____________________
Member ID:________________________

Prescriber: Name______________________
Address ______________________
City, State, Zip_____________________
Phone _____________________
Fax _____________________
NPI _____________________

Medication Requested:____________ Qty Requested: ___________

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. Will Cimzia be administered in combination with a BIOLOGIC disease-modifying antirheumatic drug (DMARD) or in combination with a targeted synthetic DMARD?
   - ☐ Biologic DMARD
   - ☐ Conventional synthetic DMARD
   - ☐ No, this medication will NOT be used in combination with another BIOLOGIC or Targeted Synthetic disease-modifying antirheumatic drug (DMARD)
2. ☐ Yes ☐ No Is the patient currently receiving Cimzia?
3. What is the indication or diagnosis?
   - ☐ Crohn's disease in an adult (this includes patients with fistulizing Crohn's disease or Crohn's disease of the ileal pouch.) – **Please answer questions 4 – 6 & 19**
   - ☐ Rheumatoid arthritis – **Please answer questions 7, 8, 12 & 20**
   - ☐ Psoriatic arthritis (PsA) **– Please answer questions 13 & 21**
   - ☐ Ankylosing spondylitis (AS) **– Please answer questions 9 & 12**
   - ☐ Non-radiographic axial spondylitis (nr-axSpA) **– Please answer questions 9, 12, 22 & 23**
   - ☐ Spondyloarthritis (SpA), other subtypes **– Please answer questions 9 – 12**
   - ☐ Plaque psoriasis **– Please answer questions 14 – 18**
   - ☐ All other indications or diagnosis (Please specify): ____
4. ☐ Yes ☐ No Has the patient tried corticosteroids, or is the patient currently on corticosteroids, or are corticosteroids contraindicated in this patient?
5. ☐ Yes ☐ No Has the patient tried one other systemic agent for Crohn's disease?
6. ☐ Yes ☐ No Is the requested medication prescribed by or in consultation with a gastroenterologist?
7. ☐ Yes ☐ No Has the patient tried one conventional synthetic disease-modifying antirheumatic drug (DMARD) for at least 3 months?
8. ☐ Yes ☐ No Has the patient tried one biologic for at least 3 months?

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9. ☐ Yes ☐ No Has the patient had a response, as determined by the prescriber?
10. ☐ Yes ☐ No Does the patient have arthritis primarily in the knees, ankles, elbows, wrists, hands and/or feet?
11. ☐ Yes ☐ No Has the patient tried at least ONE conventional synthetic DMARD?
12. ☐ Yes ☐ No Is Cimzia being prescribed by, or in consultation with, a rheumatologist?
13. ☐ Yes ☐ No Is Cimzia being prescribed by, or in consultation with, a rheumatologist or a dermatologist?
14. ☐ Yes ☐ No Has the patient tried at least one traditional systemic agent for psoriasis for at least 3 months, unless intolerant?
15. ☐ Yes ☐ No Has the patient already had a 3-month trial or previous intolerance to at least one biologic?
16. ☐ Yes ☐ No Does the patient have a contraindication to methotrexate, as determined by the prescriber?
17. ☐ Yes ☐ No Is the requested medication being prescribed by or in consultation with a dermatologist?
18. ☐ Yes ☐ No Has the patient had a response, as determined by the prescriber?
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19. ☐ Yes ☐ No Has the patient had a response as determined by the prescriber?
20. ☐ Yes ☐ No Has the patient had a response, as determined by the prescriber?
21. ☐ Yes ☐ No Has the patient had a response as determined by the prescriber?
22. ☐ Yes ☐ No Does the patient have objective signs of inflammation, defined as: a C-reactive protein (CRP) elevated beyond the upper limit of normal for the reporting laboratory?
23. ☐ Yes ☐ No Does the patient have objective signs of inflammation, defined as: sacroiliitis reported on magnetic resonance imaging (MRI)?

Please document the diagnoses, symptoms, and/or any other information important to this review:

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SECTION B Physician Signature

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PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior

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If you have any questions, call: 800-753-2851

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authorization as per Plan policy and procedures.

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