PRIOR AUTHORIZATION REQUEST

Cimzi

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests.

1	Will the requested medication be used in combination with a biologic or targeted synthetic disease-modifying antirheumatic drug (DMARD) used for an inflammatory condition? [Note: Biologic DMARDs include Actemra (IV or SC), Kevzara, Cosentyx, Kineret, Orencia (IV or SC), a rituximab product (for example, Rituxan, Truxima), Cimzia, Enbrel, Humira, an infliximab product (for example, Remicade, Inflectra, Renflexis), Simponi (Aria or SC), Ilumya, Siliq, Stelara (IV or SC), or Taltz and targeted synthetic DMARDs include Xeljanz/XR, Olumiant, Rinvoq, or Otezla.] [If yes, no further questions.]	Yes	No
2	Is the patient currently receiving the requested medication? [If no, skip to question 20.]	Yes	No

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PRIOR AUTHORIZATION REQUEST

3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 20.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 19.]	Yes	No
5	Has the patient been on established therapy for at least 3 months? [If no, skip to question 20.]	Yes	No
6	What is the diagnosis or indication? [] Crohn's disease in an adult (this includes patients with fistulizing Crohn's disease or Crohn's disease of the ileal pouch) (If checked, go to 7) [] Rheumatoid arthritis (If checked, go to 8) [] Psoriatic arthritis (PsA) (If checked, go to 10) [] Ankylosing spondylitis (AS) (If checked, go to 12) [] Non-radiographic axial spondylitis (nr-axSpA) (If checked, go to 15) [] Spondyloarthritis (SpA), other subtypes (for example, undifferentiated arthritis, reactive arthritis [Reiter's disease]) [Note: For ankylosing spondylitis, psoriatic arthritis, or non-radiographic axial spondyloarthritis, refer to the respective criteria] (If checked, go to 16) [] Plaque psoriasis (If checked, go to 17) [] Other (If checked, no further questions)		
7	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the prescriber? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
8	Has the patient experienced a beneficial clinical response when assessed by at least one objective measure? [Note: Examples of standardized and validated measures of disease activity include Clinical Disease Activity Index (CDAI), Disease Activity Score (DAS) 28 using erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP), Patient Activity Scale (PAS)-II, Rapid Assessment of Patient Index Data 3 (RAPID-3), and/or Simplified Disease Activity Index (SDAI).] [If yes, no further questions.]	Yes	No
9	Has the patient experienced an improvement in at least ONE symptom, such as	Yes	No

PRIOR AUTHORIZATION REQUEST

	decreased joint pain, morning stiffness, or fatigue; improved function or activities of daily living; decreased soft tissue swelling in joints or tendon sheaths? [No further questions.]		
10	Has the patient experienced a beneficial clinical response from baseline (prior to initiating the requested medication) by at least one objective measure? [Note: Examples of objective measures of disease activity include Disease Activity Index for Psoriatic Arthritis (DAPSA), Composite Psoriatic Disease Activity Index (CPDAI), Psoriatic Arthritis Disease Activity Score (PsA DAS), Grace Index, Leeds Enthesitis Score (LEI), Spondyloarthritis Consortium of Canada (SPARCC) enthesitis score, Leeds Dactylitis Instrument Score, Minimal Disease Activity (MDA), Psoriatic Arthritis Impact of Disease (PsAID-12), and/or serum markers (for example, C- reactive protein, erythrocyte sedimentation rate).] [If yes, no further questions.]	Yes	No
11	Compared with baseline (prior to initiating the requested medication), has the patient experienced an improvement in at least one symptom, such as less joint pain, morning stiffness, or fatigue; improved function or activities of daily living; or decreased soft tissue swelling in joints or tendon sheaths? [No further questions.]	Yes	No
12	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the prescriber? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
13	Has documentation been submitted to confirm that the patient experienced a beneficial clinical response from baseline (prior to initiating the requested medication) by at least one objective measure? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of objective measures include Ankylosing Spondylitis Disease Activity Score (ASDAS), Ankylosing Spondylitis Quality of Life Scale (ASQoL), Bath Ankylosing Spondylitis Disease Activity Index (BASDAI), Bath Ankylosing Spondylitis Functional Index (BASFI), Bath Ankylosing Spondylitis Global Score (BAS-G), Bath Ankylosing Spondylitis Metrology Index (BASMI), Dougados Functional Index (DFI), Health Assessment Questionnaire for the Spondyloarthropathies (HAQ-S), and/or serum markers (such as, C-reactive protein, erythrocyte sedimentation rate).] [If yes, no further questions.]	Yes	No
14	Compared with baseline (prior to initiating the requested medication), has the patient experienced an improvement in at least one symptom, such as decreased pain or stiffness, or improvement in function or activities of daily living? [No further questions.]	Yes	No
15	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the prescriber? ACTION REQUIRED: Submit supporting documentation.	Yes	No

PRIOR AUTHORIZATION REQUEST

	[No further questions.]		
16	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the prescriber? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
17	Compared with baseline (prior to initiating the requested medication), has the patient experienced a beneficial clinical response, in at least one of the following: estimated body surface area, erythema, induration/thickness, and/or scale of areas affected by psoriasis? [If no, no further questions.]	Yes	No
18	Compared with baseline (prior to initiating the requested medication), has the patient experienced an improvement in at least one symptom, such as decreased pain, itching, and/or burning? [No further questions.]	Yes	No
19	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the prescriber? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
20	What is the diagnosis or indication? [] Crohn's disease in an adult (this includes patients with fistulizing Crohn's disease or Crohn's disease of the ileal pouch) (If checked, go to 21) [] Rheumatoid arthritis (If checked, go to 29) [] Psoriatic arthritis (PsA) (If checked, go to 36) [] Ankylosing spondylitis (AS) (If checked, go to 43) [] Non-radiographic axial spondylitis (nr-axSpA) (If checked, go to 49) [] Spondyloarthritis (SpA), other subtypes (for example, undifferentiated arthritis, reactive arthritis [Reiter's disease]) [Note: For ankylosing spondylitis, psoriatic arthritis, or non-radiographic axial spondyloarthritis, refer to the respective criteria] (If checked, go to 55) [] Plaque psoriasis (If checked, go to 61) [] Other (If checked, no further questions)		
21	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
22	Has the patient tried corticosteroids, or is the patient currently on corticosteroids? [If yes, skip to question 24.]	Yes	No

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PRIOR AUTHORIZATION REQUEST

23	Does the patient have a contraindication to corticosteroids? [If no, no further questions.]	Yes	No
24	Has the patient tried one other systemic agent for Crohn's disease for at least 3 months? [Note: Examples of systemic therapies for Crohn's disease include azathioprine, 6-mercaptopurine, methotrexate. A trial of mesalamine does not count as a systemic agent for Crohn's disease.] [If yes, skip to question 26.]	Yes	No
25	Has documentation been submitted to confirm that the patient has an intolerance to at least TWO systemic agents? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of systemic therapies for Crohn's disease include azathioprine, 6-mercaptopurine, methotrexate. A trial of mesalamine does not count as a systemic agent for Crohn's disease.] [If no, no further questions.]	Yes	No
26	Has documentation been submitted to confirm that the patient has had a treatment failure with the preferred TNF inhibitor, an adalimumab product (Hadlima, Yusimry, or adalimumab-adbm), for at least 3 months or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
27	Does the requested dose exceed the Food and Drug Administration approved label dosing for the indication? [If yes, no further questions.]	Yes	No
28	Is the requested medication being prescribed by or in consultation with a gastroenterologist? [No further questions.]	Yes	No
29	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
30	Has the patient tried TWO conventional synthetic disease-modifying antirheumatic drugs (DMARD) for at least 3 months? [Note: Examples of conventional synthetic DMARDs include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.] [If yes, skip to question 32.]	Yes	No
31	Has documentation been submitted to confirm that the patient has an intolerance to at least TWO conventional synthetic DMARDs? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of conventional synthetic DMARDs include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.] [If no, no further questions.]	Yes	No

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PRIOR AUTHORIZATION REQUEST

32	Has documentation been submitted to confirm that the patient has had a treatment failure with preferred TNF inhibitors, Enbrel (etanercept) and an adalimumab product (Hadlima, Yusimry, or adalimumab-adbm) for at least 3 months or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
33	Has documentation been submitted to confirm that the patient has had a treatment failure with Xeljanz (tofactinib) for at least 3 months, or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
34	Is the requested medication being prescribed by, or in consultation with, a rheumatologist? [If no, no further questions.]	Yes	No
35	Does the requested dose exceed the Food and Drug Administration approved label dosing for the indication? [No further questions.]	Yes	No
36	Is the requested medication being prescribed by or in consultation with a rheumatologist or a dermatologist? [If no, no further questions.]	Yes	No
37	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
38	Does the requested dose exceed the Food and Drug Administration approved label dosing for the indication? [If yes, no further questions.]	Yes	No
39	Has documentation been submitted to confirm that the patient has had a treatment failure with the preferred TNF inhibitors, Enbrel (etanercept) and an adalimumab product (Hadlima, Yusimry, or adalimumab-adbm) for at least 3 months or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
40	Has documentation been submitted to confirm that the patient has had a treatment failure with Xeljanz (tofactinib) for at least 3 months, or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
41	Has the patient tried TWO conventional synthetic disease-modifying antirheumatic drugs (DMARD) for at least 3 months? [Note: Examples of conventional synthetic DMARDs include methotrexate (oral or	Yes	No

PRIOR AUTHORIZATION REQUEST

	injectable), leflunomide, hydroxychloroquine, and sulfasalazine.] [If yes, no further questions.]		
42	Has documentation been submitted to confirm that the patient has an intolerance to at least TWO conventional synthetic DMARDs? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of conventional synthetic DMARDs include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.] [No further questions.]	Yes	No
43	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
44	Does the patent have a documented diagnosis of active ankylosing spondylitis? [If no, no further questions.]	Yes	No
45	Has documentation been submitted to confirm that the patient has had a treatment failure with the preferred TNF inhibitors, Enbrel (etanercept) and an adalimumab product (Hadlima, Yusimry, or adalimumab-adbm) for at least 3 months, or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
46	Has documentation been submitted to confirm that the patient has had a treatment failure with Xeljanz (tofactinib) for at least 3 months, or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
47	Does the requested dose exceed the Food and Drug Administration approved label dosing for the indication? [If yes, no further questions.]	Yes	No
48	Is the requested medication being prescribed by, or in consultation with, a rheumatologist? [No further questions.]	Yes	No
49	Is the requested medication being prescribed by, or in consultation with, a rheumatologist? [If no, no further questions.]	Yes	No
50	Does the patient have an objective sign of inflammation, defined as: a C-reactive protein (CRP) elevated beyond the upper limit of normal for the reporting laboratory? [If yes, skip to question 52.]	Yes	No
51	Does the patient have an objective sign of inflammation, defined as: sacroiliitis reported on magnetic resonance imaging (MRI)?	Yes	No

PRIOR AUTHORIZATION REQUEST

	[If no, no further questions.]		
52	Has the patient tried and failed prescription strength NSAIDs for at least 4 weeks? [If no, no further questions.]	Yes	No
53	Has documentation been submitted to confirm that the patient has had a treatment failure with preferred TNF inhibitors, Enbrel (etanercept) and an adalimumab product (Hadlima, Yusimry, or adalimumab-adbm) for at least 3 months, or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
54	Does the requested dose exceed the Food and Drug Administration approved label dosing for the indication? [No further questions.]	Yes	No
55	Does the patient have arthritis primarily in the knees, ankles, elbows, wrists, hands and/or feet? [If no, no further questions.]	Yes	No
56	Has the patient tried at least TWO conventional synthetic DMARDs for at least 3 months? [Note: Examples include methotrexate (MTX), leflunomide, and sulfasalazine.] [If yes, skip to question 58.]	Yes	No
57	Has documentation been submitted to confirm that the patient has an intolerance to at least TWO conventional synthetic DMARDs? ACTION REQUIRED: Submit supporting documentation. [Note: Examples include methotrexate (MTX), leflunomide, and sulfasalazine.] [If no, no further questions.]	Yes	No
58	Has documentation been submitted to confirm that the patient has had a treatment failure with the preferred TNF inhibitors, Enbrel (etanercept) and an adalimumab product (Hadlima, Yusimry, or adalimumab-adbm) for at least 3 months, or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
59	Does the requested dose exceed the Food and Drug Administration approved label dosing for the indication? [If yes, no further questions.]	Yes	No
60	Is the requested medication being prescribed by, or in consultation with, a rheumatologist? [No further questions.]	Yes	No
61	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No

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PRIOR AUTHORIZATION REQUEST

62	Has the patient tried at least TWO traditional systemic agents for psoriasis for at least 3 months? [Note: Examples of traditional systemic agents for psoriasis include methotrexate (MTX), cyclosporine, acitretin tablets, or psoralen plus ultraviolet A light (PUVA).] [If yes, skip to question 64.]	Yes	No
63	Has documentation been submitted to confirm the patient has an intolerance to at least TWO traditional systemic agents for psoriasis? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of traditional systemic agents for psoriasis include methotrexate (MTX), cyclosporine, acitretin tablets, or psoralen plus ultraviolet A light (PUVA).] [If no, no further questions.]	Yes	No
64	Has documentation been submitted to confirm that the patient has had a treatment failure with the preferred TNF inhibitors, Enbrel (etanercept) and an adalimumab product (Hadlima, Yusimry, or adalimumab-adbm) for at least 3 months, or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
65	Is the requested medication being prescribed by or in consultation with a dermatologist? [If no, no further questions.]	Yes	No
66	Does the requested dose exceed the Food and Drug Administration approved label dosing for the indication?	Yes	No

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

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

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 authorization as per Plan policy and procedures.

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