PRIOR AUTHORIZATION REQUEST

Cimzia

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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

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

If you have any questions, call: 1-888-258-8250

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2	Is the patient currently receiving the requested medication? [If no, skip to question 7.]	Yes	No
3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 7.]	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 7.]	Yes	No
5	Has the patient been on established therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	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
7	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 8) [] Rheumatoid arthritis (If checked, go to 14) [] Psoriatic arthritis (PsA) (If checked, go to 19) [] Ankylosing spondylitis (AS) (If checked, go to 25) [] Non-radiographic axial spondylitis (nr-axSpA) (If checked, go to 30) [] 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 37) [] Plaque psoriasis (If checked, go to 43) [] Polyarticular juvenile idiopathic arthritis (pJIA) (If checked, go to 50) [] Other (If checked, no further questions)		
8	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
9	Has documentation been submitted to confirm the patient has had a treatment failure with two other systemic agents for Crohn's disease for at least 3 months or	Yes	No

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	is the patient intolerant or the medication contraindicated? 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.]		
10	Has documentation been submitted to confirm that the patient has had a treatment failure with the preferred TNF inhibitor, an adalimumab product (Simlandi, 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
11	Has documentation been submitted to confirm that the patient has had a treatment failure with a preferred ustekinumab product (Yesintek, Pyzchiva, Steqeyma), 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
12	Does the requested dose exceed the Food and Drug Administration approved label dosing for the indication? (Dosing: 400mg at weeks 0, 2, 4 and then 400mg every 4 weeks thereafter) [If yes, no further questions.]	Yes	No
13	Is the requested medication being prescribed by, or in consultation with, a gastroenterologist? [No further questions.]	Yes	No
14	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
15	Has documentation been submitted to confirm the patient has tried TWO conventional synthetic disease-modifying antirheumatic drugs (DMARDs) for at least 3 months or is the patient intolerant or the medication contraindicated? 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
16	Has documentation been submitted to confirm that the patient has had a treatment failure with 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

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17	Is the requested medication being prescribed by, or in consultation with, a rheumatologist? [If no, no further questions.]	Yes	No
18	Does the requested dose exceed the Food and Drug Administration approved label dosing for the indication? (Dosing: 400mg at weeks 0, 2, 4 and then 200mg every 2 weeks thereafter) [No further questions.]	Yes	No
19	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
20	Has documentation been submitted to confirm the patient has tried TWO conventional synthetic disease-modifying antirheumatic drugs (DMARDs) for at least 3 months or is the patient intolerant or the medication contraindicated? 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
21	Has documentation been submitted to confirm that the patient has had a treatment failure with the preferred TNF inhibitor, an adalimumab product (Simlandi, 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
22	Has documentation been submitted to confirm that the patient has had a treatment failure with a preferred ustekinumab product (Yesintek, Pyzchiva, Steqeyma), 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
23	Is the requested medication being prescribed by, or in consultation with, a rheumatologist or a dermatologist? [If no, no further questions.]	Yes	No
24	Does the requested dose exceed the Food and Drug Administration approved label dosing for the indication? (Dosing: 400mg at weeks 0, 2, 4 and then 200mg every 2 weeks thereafter) [No further questions.]	Yes	No
25	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
26	Does the patent have a documented diagnosis of active ankylosing spondylitis? [If no, no further questions.]	Yes	No

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27	Has documentation been submitted to confirm that the patient has had a treatment failure with the preferred TNF inhibitor, an adalimumab product (Simlandi, 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
28	Does the requested dose exceed the Food and Drug Administration approved label dosing for the indication? (Dosing: 400mg at weeks 0, 2, 4 and 200mg every 2 weeks or 400mg monthly) [If yes, no further questions.]	Yes	No
29	Is the requested medication being prescribed by, or in consultation with, a rheumatologist? [No further questions.]	Yes	No
30	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
31	Is the requested medication being prescribed by, or in consultation with, a rheumatologist? [If no, no further questions.]	Yes	No
32	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 34.]	Yes	No
33	Does the patient have an objective sign of inflammation, defined as: sacroiliitis reported on magnetic resonance imaging (MRI)? [If no, no further questions.]	Yes	No
34	Has the patient tried and failed prescription strength NSAIDs for at least 4 weeks? [If no, no further questions.]	Yes	No
35	Has documentation been submitted to confirm that the patient has had a treatment failure with preferred TNF inhibitor, an adalimumab product (Simlandi, 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
36	Does the requested dose exceed the Food and Drug Administration approved label dosing for the indication? (Dosing: 400mg at weeks 0, 2, 4 and 200mg every 2 weeks or 400mg monthly) [No further questions.]	Yes	No

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37	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
38	Does the patient have arthritis primarily in the knees, ankles, elbows, wrists, hands and/or feet? [If no, no further questions.]	Yes	No
39	Has documentation been submitted to confirm the patient has tried TWO conventional synthetic disease-modifying antirheumatic drugs (DMARDs) for at least 3 months or is the patient intolerant or the medication contraindicated? 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
40	Has documentation been submitted to confirm that the patient has had a treatment failure with the preferred TNF inhibitor, an adalimumab product (Simlandi, 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
41	Does the requested dose exceed the Food and Drug Administration approved label dosing for the indication? (Dosing: 400mg at weeks 0, 2, 4 and 200mg every 2 weeks or 400mg monthly) [If yes, no further questions.]	Yes	No
42	Is the requested medication being prescribed by, or in consultation with, a rheumatologist? [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	Has documentation been submitted to confirm that the patient has tried at least TWO traditional systemic agents for psoriasis for at least 3 months, or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of traditional systemic agents for psoriasis include methotrexate (MTX), cyclosporine, acitretin tablets.] [If no, no further questions.]	Yes	No
45	Has documentation been submitted to confirm that the patient has had treatment failure with daily use of Zoryve for at least 56 consecutive days, or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation?	Yes	No

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	[If no, no further questions.]		
46	Has documentation been submitted to confirm that the patient has had a treatment failure with the preferred TNF inhibitor, an adalimumab product (Simlandi, 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
47	Has documentation been submitted to confirm that the patient has had a treatment failure with a preferred ustekinumab product (Yesintek, Pyzchiva, Steqeyma), 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
48	Is the requested medication being prescribed by, or in consultation with, a dermatologist? [If no, no further questions.]	Yes	No
49	Does the requested dose exceed the Food and Drug Administration approved label dosing for the indication? (Dosing: 400mg every 2 weeks) [No further questions.]	Yes	No
50	Is the patient 2 years of age or older? [If no, no further questions.]	Yes	No
51	Has documentation been provided to confirm the patient has tried ONE other traditional systemic agent for at least 3 months for pJIA, or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of other agents for JIA include but not limited to methotrexate (MTX), sulfasalazine, or leflunomide or examples of contraindications to MTX include pregnancy, breast feeding, alcoholic liver disease, immunodeficiency syndrome, blood dyscrasias] [If no, no further questions.]	Yes	No
52	Has documentation been submitted to confirm that the patient has had a treatment failure with the preferred TNF inhibitor, an adalimumab product (Simlandi, 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
53	Has documentation been submitted to confirm that the patient has had a treatment failure with the preferred IL-6 inhibitor, Actemra, for at least 3 months, or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit	Yes	No

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	supporting documentation. [If no, no further questions.]		
54	Does the patient have aggressive disease, as determined by the prescriber? [If no, no further questions.]	Yes	No
55	Is the requested medication being prescribed by, or in consultation with, a rheumatologist? [If no, no further questions.]	Yes	No
56	Does the requested dose exceed the Food and Drug Administration approved label dosing for the indication? (Dosing: (100mg-400mg) at weeks 0, 2, 4 and then (50-200mg) every other week thereafter)	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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