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	Is this request for initial therapy or for a continuation of therapy? [] Initial (If checked, go to 8) [] Continuation (If checked, go to 2)		
2	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),	Yes	No

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	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.]		
3	Is the patient currently receiving the requested medication? [If no, skip to question 8.]	Yes	No
4	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 8.]	Yes	No
5	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 8.]	Yes	No
6	Has the patient been on established therapy for at least 3 months? [If no, skip to question 8.]	Yes	No
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	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
9	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 10) [] Rheumatoid arthritis (If checked, go to 16) [] Psoriatic arthritis (PsA) (If checked, go to 22) [] Ankylosing spondylitis (AS) (If checked, go to 29)		

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[] Non-radiographic axial spondylitis (nr-axSpA) (If checked, go to 35)

[] 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 42)

[] Plaque psoriasis (If checked, go to 48)

[] Polyarticular juvenile idiopathic arthritis (pJIA) (If checked, go to 54)

[] Other (If checked, no further questions)

10	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
11	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 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.]	Yes	No
12	Has documentation been submitted to confirm that the patient has had a treatment failure with the preferred tumor necrosis factor (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
13	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
14	Is the requested medication being prescribed by, or in consultation with, a gastroenterologist? [If no, no further questions.]	Yes	No
15	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Dosing is 400mg at weeks 0, 2, 4 and then 400mg every 4 weeks thereafter.] [No further questions.]	Yes	No
16	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No

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17	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
18	Has documentation been submitted to confirm that the patient has had a treatment failure with the preferred tumor necrosis factor (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
19	Has documentation been submitted to confirm that the patient has had a treatment failure with Xeljanz (tofacitinib) 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
20	Is the requested medication being prescribed by, or in consultation with, a rheumatologist? [If no, no further questions.]	Yes	No
21	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Dosing is 400mg at weeks 0, 2, 4 and then 200mg every 2 weeks thereafter.] [No further questions.]	Yes	No
22	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
23	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
24	Has documentation been submitted to confirm that the patient has had a treatment failure with the preferred tumor necrosis factor (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.	Yes	No

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	[If no, no further questions.]		
25	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
26	Has documentation been submitted to confirm that the patient has had a treatment failure with Xeljanz (tofacitinib) 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	Is the requested medication being prescribed by, or in consultation with, a rheumatologist or a dermatologist? [If no, no further questions.]	Yes	No
28	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Dosing is 400mg at weeks 0, 2, 4 and then 200mg every 2 weeks thereafter.] [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	Does the patent have a documented diagnosis of active ankylosing spondylitis? [If no, no further questions.]	Yes	No
31	Has documentation been submitted to confirm that the patient has had a treatment failure with the preferred tumor necrosis factor (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
32	Has documentation been submitted to confirm that the patient has had a treatment failure with Xeljanz (tofacitinib) 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	Is the requested medication being prescribed by, or in consultation with, a rheumatologist? [If no, no further questions.]	Yes	No
34	Does the requested dose exceed the Food and Drug Administration (FDA)	Yes	No

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	approved label dosing for the indication? [Note: Dosing is 400mg at weeks 0, 2, 4 and 200mg every 2 weeks or 400mg monthly.] [No further questions.]		
35	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
36	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 38.]	Yes	No
37	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
38	Has the patient tried and failed prescription strength nonsteroidal anti-inflammatory drugs (NSAIDs) for at least 4 weeks? [If no, no further questions.]	Yes	No
39	Has documentation been submitted to confirm that the patient has had a treatment failure with the preferred tumor necrosis factor (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
40	Is the requested medication being prescribed by, or in consultation with, a rheumatologist? [If no, no further questions.]	Yes	No
41	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Dosing is 400mg at weeks 0, 2, 4 and 200mg every 2 weeks or 400mg monthly.] [No further questions.]	Yes	No
42	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
43	Does the patient have arthritis primarily in the knees, ankles, elbows, wrists, hands and/or feet? [If no, no further questions.]	Yes	No
44	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?	Yes	No

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	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.]		
45	Has documentation been submitted to confirm that the patient has had a treatment failure with the preferred tumor necrosis factor (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
46	Is the requested medication being prescribed by, or in consultation with, a rheumatologist? [If no, no further questions.]	Yes	No
47	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Dosing is 400mg at weeks 0, 2, 4 and 200mg every 2 weeks or 400mg monthly.] [No further questions.]	Yes	No
48	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
49	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
50	Has documentation been submitted to confirm that the patient has had a treatment failure with the preferred tumor necrosis factor (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
51	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
52	Is the requested medication being prescribed by, or in consultation with, a dermatologist?	Yes	No

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	[If no, no further questions.]		
53	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Dosing is 400mg every 2 weeks.] [No further questions.]	Yes	No
54	Is the patient 2 years of age or older? [If no, no further questions.]	Yes	No
55	Has documentation been provided to confirm the patient has tried ONE other traditional systemic agent for at least 3 months for polyarticular juvenile idiopathic arthritis (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
56	Has documentation been submitted to confirm that the patient has had a treatment failure with the preferred tumor necrosis factor (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
57	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 supporting documentation. [If no, no further questions.]	Yes	No
58	Does the patient have aggressive disease, as determined by the prescriber? [If no, no further questions.]	Yes	No
59	Is the requested medication being prescribed by, or in consultation with, a rheumatologist? [If no, no further questions.]	Yes	No
60	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Dosing is (100mg-400mg) at weeks 0, 2, 4 and then (50-200mg) every other week thereafter.]	Yes	No

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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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