Please Note: Medical Necessity Prior Authorization may be overrided for both formulary coverage and benefit design restrictions. They are issued at the full discretion of the benefit manager.

PRIOR AUTHORIZATION **BYPASS**

Cimzia® (certolizumab pegol)

Bypass the Prior Authorization by Modifying the following Prescription Forms to the Patient's Needs

Name _____

Address _____

℞

Refer for Protocols for UC/Crohn's Disease

MD _____

Signature _____

Name _____

Address _____

℞ COMPLETE PRIOR AUTHORIZATION FORMS

as directed by physician

Dx: CROHN'S/ ULCERATIVE COLITIS

ICD 10: K 50.19

MD _____

Signature _____

usDoctor

Prescriber Information

Last Name:	**First Name**
DEA/NPI:	**Specialty:**
Phone - -	**Fax** - -

Member Information

Last Name:	**First Name**
Member ID Number	**DOB:** - -

Medication Information:

Drug Name and Strength:	Quantity and Dosing:
Diagnosis:	Duration:

When advised below, please include all requested fax documentation (lab results, etc.) when submitting this Prior Authorization fax form; not submitting requested documentation could delay the clinical review process.

Cimzia Prior Authorization Form

Initial Therapy **You must answer ALL of the following questions**		
1. Is the patient 18 years of age or older?	Y	N
2. Does the patient have one of the following diagnoses? **(If yes, please circle)** • Moderate to severely active Rheumatoid Arthritis (RA) • Moderate to severely active Crohn's Disease • Moderate to severely active Psoriatic Arthritis • Ankylosing Spondylitis	Y	N
RHEUMATOID ARTHRITIS (RA)		
3. Is the requested medication prescribed by a Rheumatologist?	Y	N
4. Has the patient had a trial with methotrexate or another oral non-biologic disease modifying anti-rheumatic agent (DMARD) such as Imuran, Ridaura, Cuprimine, or Arava?	Y	N
5. Is the patient unable to take the prerequisite non-biologic DMARD due to their chronic liver disease (such as chronic hepatitis, fatty liver, nonalcoholic steatohepatitis/NASH, or elevated liver enzymes)?	Y	N
6. Is the patient on concurrent treatment with another TNF inhibitor?	Y	N
7. Has the patient tried and had an inadequate response to a three month trial of Enbrel AND Humira?	Y	N
8. Has the patient been treated with, and had an inadequate response to Remicade and/or Orencia?	Y	N
9. Has the patient tried and had an inadequate response to a three month trial of Humira OR Enbrel?	Y	N

PSORIATIC ARTHRITIS		
3. Is the requested medication prescribed by a Rheumatologist or Dermatologist?	Y	N
4. Has the patient had at least a 3 month trial and failed previous therapy with an oral non-biologic disease modifying anti-rheumatic agent (DMARD) (e.g., methotrexate, azathioprine (Imuran), auranofin (Ridaura), hydroxychloroquine (Plaquenil), penicillamine (Cuprimine), sulfasalazine (Azulfidine), or leflunomide (Arava))?	Y	N
5. Is the patient unable to take the prerequisite non-biologic DMARD due to their chronic liver disease (such as chronic hepatitis, fatty liver, nonalcoholic steatohepatitis/NASH, or elevated liver enzymes)? If not, provide rationale as to why the patient has not taken the prerequisite non-biologic DMARD:_____	Y	N
6. Is the patient on concurrent treatment with another TNF inhibitor?	Y	N
7. Has the patient tried and had an inadequate response to a three month trial of Enbrel?	Y	N
8. Has the patient tried and had an inadequate response to a three month trial of Humira?	Y	N
CROHN'S DISEASE		
3. Is the requested medication prescribed by a Gastroenterologist?	Y	N
4. Is the patient on concurrent treatment with another TNF inhibitor?	Y	N
5. Does the patient have documented trial and failure on oral immunosuppressive therapy for at least 3 months or is use with these agents contraindicated (i.e., corticosteroids, methotrexate, azathioprine, and/or 6-mercaptopurine)? If yes, please provide documentation of therapies tried or contraindications to therapy: _____	Y	N
6. Has the patient tried and had an inadequate response to a three month trial of Humira?	Y	N
ANKYLOSING SPONDYLITIS		
3. Is the requested medication prescribed by a Rheumatologist?	Y	N
4. Has the patient had an adequate trial and failure of at least two non-steroidal anti-inflammatory agents (NSAIDs) or is use with these agents contraindicated? If yes, please provide documentation of therapies tried or contraindications to therapy:_____ _____	Y	N
5. Is the patient on concurrent treatment with another TNF inhibitor?	Y	N
6. Has the patient tried and had an inadequate response to a three month trial of Enbrel?	Y	N
7. Has the patient tried and had an inadequate response to a three month trial of Humira?	Y	N

Renewal Therapy **You must answer ALL of the following questions**		
1. Does the patient have one of the following diagnoses? **(If yes, please circle)** • Moderate to severely active Rheumatoid Arthritis (RA) • Moderate to severely active Crohn's Disease • Moderate to severely active Psoriatic Arthritis • Ankylosing Spondylitis	Y	N
2. Is the requested medication prescribed by a Rheumatologist?	Y	N
3. Is the requested medication prescribed by a Dermatologist?	Y	N
4. Is the requested medication prescribed by a Gastroenterologist?	Y	N
5. Is the patient continuing to have a positive clinical response and has remission of the disease been maintained with continued use? *Must be confirmed by provided chart notes.*	Y	N

Please note, not all drugs/diagnoses are covered on all plans.

Comments: _____

Information given on this form is accurate as of this date.

Prior Authorization forms are located on the Cover Page. Print a new form for each request as forms are updated periodically.

_____ _____

Prescriber or Authorized Signature **Date**

_____

Authorized Medical Staff – Name/Title

Attention Healthcare Provider: If you would like to discuss this request with a medical professional, please contact the Prior Authorization Department whose numbers appear on the Cover Page.

I understand that USDoctor's use or disclosure of individually identifiable health information, whether furnished by me or obtained by another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

Contact Information:

Telephone: (855)251.9116
Fax: (248)593.9575

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PRIOR AUTHORIZATION FORM:
COVER PAGE

MEMBER INFORMATION			
First Name		**Last Name**	
Plan			
Member ID		**Date of Birth**	

DRUG INFORMATION			
Drug Name			
Quantity		**ICD-10**	
Directions		**Duration of Therapy**	
Diagnosis			

PLEASE LIST ALTERNATIVE THERAPIES THAT HAVE BEEN ATTEMPTED AND ANY OTHER PERTINENT INFORMATION RELATED TO DRUG AND/OR DISEASE STATE. IF NOT PRESENT, WITHIN NORMAL LIMITS WILL BE USED FOR THE REVIEW.

Medication/Failure Reason:

IgE:_____

ESR:_____ **CRP:**_____ **# Joints:**_____ **%BSA:**_____

Height:_____ **Weight:**_____ **BMI:**_____

HA1C:_____ **Hemoglobin:**_____ **Hematocrit:**_____ **T-Score:**_____

Dialysis:_____ **Long Term Care Facility:**_____ **Self Injecting:**_____

Stimulation test:_____/_____ **Growth velocity:**_____ **#Chemotherapy cycles/month:**_____

Mini-Mental Status Test:_____ **Baseline Free testosterone/Total testosterone:**_____/_____

HCV RNA viral load:_____ **Viral Genotype:**_____ **ALT:**_____

PHYSICIAN INFORMATION			
Physician Signature		**Date**	
Physician Name		**NPI #**	
Phone Number		**Fax Number**	
Action Needed	Only mark Urgent when standard review time would seriously harm the member's life or health or ability to regain maximum function ☐ Urgent ☐ For Review	**Pharmacy Fax**	