pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

CIMZIA (certolizumab pegol) [non-preferred] PRIOR AUTHORIZATION FORM

Cytokine and CAM Antagonists and **Quantity Limits/Daily Dose Limits** prior authorization guidelines: http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Product requested: Cimzia ☐vial kit ☐starter kit ☐syringe kit ☐other: _____		Strength:
Directions:	Quantity:	Refills:
Diagnosis (*submit documentation*):	Diagnosis code (*required*):	

Specialty Pharmacy Drug Program: Which specialty pharmacy will be used? ☐Diplomat Specialty ☐Walgreen's Specialty

INITIAL requests – complete questions applicable to beneficiary's diagnosis

1.	***All diagnoses***: Check all that apply to the beneficiary and *submit documentation for each*. ☐vaccinated for hepatitis B ☐screened for hepatitis B (surface antigen & core antibody) ☐has been using Cimzia in the past 90 days ☐screened for tuberculosis ☐up-to-date with all age-appropriate immunizations	
2.	***Ankylosing spondylitis or psoriatic arthritis*:** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the following? ☐four-week trial each of at least 2 different NSAIDs ☐eight-week trial of methotrexate or other DMARD *(does not apply to axial disease)*	☐Yes ☐No *Submit documentation of all medications tried and outcomes.*
3.	***Ankylosing spondylitis*:** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agents? *Check all that apply.* ☐Cosentyx ☐Humira	☐Yes ☐No *Submit documentation of all medications tried and outcomes.*
4.	***Plaque psoriasis:*** Does at least one of the following apply to the beneficiary? ☐≥ 5% of body surface area affected ☐critical areas of the body are involved	☐Yes ☐No *Submit documentation.*
5.	***Plaque psoriasis:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the following treatments and medications? *Check all that apply.* ☐3 months of PUVA ☐3 months of UVB light ☐methotrexate ☐Cosentyx ☐acitretin ☐cyclosporine ☐Humira	☐Yes ☐No *Submit documentation treatments tried and outcomes.*
6.	***Psoriatic arthritis*:** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agents? *Check all that apply.* ☐Cosentyx ☐Humira ☐Xeljanz	☐Yes ☐No *Submit documentation of all medications tried and outcomes.*
7.	***Rheumatoid arthritis*:** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of at least 3 months of treatment with methotrexate or another DMARD?	☐Yes ☐No *Submit documentation of all medications tried and outcomes.*
8.	***Rheumatoid arthritis*:** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agents? *Check all that apply.* ☐Humira ☐Xeljanz	☐Yes ☐No *Submit documentation of all medications tried and outcomes.*
9.	***Crohn's disease:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the following? ☐aminosalicylates ☐corticosteroids ☐immunomodulators	☐Yes ☐No *Submit documentation of all medications tried and outcomes.*
10.	***Crohn's disease:*** Does the beneficiary have a history **of** trial and failure, contraindication, or intolerance of the preferred agent, **Humira**?	☐Yes ☐No *Submit documentation of all medications tried and outcomes.*
11.	***For all other diagnoses***, submit documentation supporting the use of Cimzia for the beneficiary's diagnosis & other treatments tried.	

RENEWAL requests

1.	Since starting Cimzia, did the beneficiary experience a positive clinical response and/or improved level of functioning?	☐Yes ☐No *Submit documentation of clinical response.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: