



Cimzia (certolizumab pegol)
Prior Authorization Request Form



Caterpillar Prescription Drug Benefit
 Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA. **URGENT**

MEMBER INFORMATION		
LAST NAME:	FIRST NAME:	
PHONE NUMBER:	DATE OF BIRTH:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
PATIENT INSURANCE ID NUMBER:		

MALE FEMALE HEIGHT (IN/CM): _____ WEIGHT (LB/KG): _____ ALLERGIES: _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: [HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF](https://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF)

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____

AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION		
LAST NAME:	FIRST NAME:	
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:	
NPI NUMBER:	DEA NUMBER:	
PHONE NUMBER:	FAX NUMBER:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:	

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page





**Cimzia (certolizumab pegol)
Prior Authorization Request Form**



Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ MEMBER'S FIRST NAME: _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? YES (if yes, complete below) NO

MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:

2. LIST DIAGNOSES: **ICD-10:**

<input type="checkbox"/> Ankylosing spondylitis <input type="checkbox"/> Moderate to severely active Crohn's disease <input type="checkbox"/> Moderate to severe plaque psoriasis <input type="checkbox"/> Moderate to severe active psoriatic arthritis <input type="checkbox"/> Moderate to severely active rheumatoid arthritis <input type="checkbox"/> Plaque Psoriasis <input type="checkbox"/> Active non-radiological axial spondylarthritis <input type="checkbox"/> Other Diagnosis _____ ICD-10 Code(s): _____	
--	--

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:
 Select if Cimzia is prescribed by one of the following specialist:
 Dermatologist Gastroenterologist Rheumatologist
 Is the patient on concurrent treatment with another TNF inhibitor? Yes No
 Has the patient tried and had an inadequate response to a three month trial of Enbrel? Yes No
 Has the patient tried and had an inadequate response to a three month trial of Humira? Yes No

For ankylosing spondylitis, also answer the following:
 Has the patient had an adequate trial and failure of at least TWO non-steroidal anti-inflammatory agents (NSAIDs)?
 Yes No (Provide NSAIDs and dates of service)
 Has the patient tried methotrexate? Yes No (Provide dates of service)

For moderate to severely active Crohn's disease, also answer the following:
 Does the patient have documented trial and failure on oral immunosuppressive therapy (i.e., corticosteroids, methotrexate, azathioprine, and/or 6-mercaptopurine)? Yes No

For moderate to severely active psoriatic arthritis, also answer the following:
 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, sulfasalazine [Azulfidine], or leflunomide [Arava], or cyclosporine)? Yes No

Does the patient have chronic liver disease such as chronic alcohol abuse/alcoholism, chronic hepatitis, fatty liver, nonalcoholic, steatohepatitis (NASH), or elevated liver enzymes? Yes No





**Cimzia (certolizumab pegol)
Prior Authorization Request Form**

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640



MEMBER'S LAST NAME: _____ MEMBER'S FIRST NAME: _____

For moderate to severely active rheumatoid arthritis, also answer the following:

Has the patient had a trial with methotrexate or another oral non-biologic disease modifying anti-rheumatic agent (DMARD) such as Imuran, Ridaura, Arava, Plaquenil, or sulfasalazine? Yes No

Does the patient have chronic liver disease such as chronic hepatitis, fatty liver, nonalcoholic steatohepatitis (NASH), or elevated liver enzymes)? Yes No

Has the patient been treated with and had an inadequate response to Remicade and/or Orencia? Yes No

Moderate to severe plaque Psoriasis:

Is the patient ≥18 years of age? Yes No

Does the patient have plaques covering > 3% of their body surface area (BSA) or < 3% of BSA? Yes No

Is topical therapy no longer tolerated or effective with agents such as corticosteroids, anthralin, calcipotriene, or Tazarotene for the patient? Yes No

Select if the patient has had previous treatment failure with the following

- Phototherapy
- Psoralens with UVA light (PUVA)
- UVB with coal tar

Has the patient had previous treatment failure with an oral systemic therapy (e.g., acitretin, methotrexate or cyclosporine)? Yes No

If "no" to the above question, does the patient have a contraindication to ALL oral systemic treatments?*

Yes No

****Documentation of a contraindication to ALL oral systemic treatments must be submitted.***

For Active non-radiological axial spondylarthritis:

Please submit chart notes corroborating patient has active non-radiological axial spondyloarthritis, AND a submitted radiology report documenting the absence of sacroiliitis on SI joint x-rays.

Has patient had active axial spondyloarthritis for at least 12 months? Yes No

Does patient have objective signs of inflammation indicated by C-reactive protein(CRP) levels above the upper limit of normal? Yes No *Please submit lab report.*





**Cimzia (certolizumab pegol)
Prior Authorization Request Form**

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640



MEMBER'S LAST NAME: _____ MEMBER'S FIRST NAME: _____

Does patient have documented sacroiliitis on magnetic resonance imaging (MRI) ? Yes No *Please submit MRI report.*

Does patient have an intolerance to or an inadequate response to at least two NSAIDs? Yes No

Does patient have fibromyalgia? Yes No

Reauthorization:

If this is a reauthorization request, answer the following questions:

Is the patient continuing to have a positive clinical response and remission of disease is maintained with continued use? * Yes No

*Must be confirmed by provided chart notes.

Select if Cimzia is prescribed by one of the following specialist:

- Dermatologist
- Gastroenterologist
- Rheumatologist

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.

4801 E. Washington Street, Phoenix, AZ 85034

Phone: 877-228-7909

