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

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	☐ Yes proceed to question **2**	☐ No proceed to question **4**
2. Has the patient had an inadequate response to Humira?	☐ Yes proceed to question **5**	☐ No proceed to question **3**
3. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
4. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Is the patient 18 years of age or older?	☐ Yes proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Cases of worsening congestive heart failure (CHF) and new onset CHF have been reported with TNF blockers, including CIMIZA. Is the prescriber aware of this?	☐ Yes proceed to question **7**	☐ No **STOP** **Coverage not approved**

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7.	**What is the indication or diagnosis?**	☐ moderate to severe active **rheumatoid arthritis** – proceed to question **10** ☐ active **psoriatic arthritis** – proceed to question **10** ☐ active **ankylosing spondylitis** – proceed to question **11** ☐ moderately to severely active **Crohn's disease** – proceed to question **10** ☐ moderate to severe plaque psoriasis - proceed to question **8** ☐ active non-radiographic **axial spondyloarthritis** with objective signs of inflammation - proceed to question **9** ☐ other indication or diagnosis – **STOP: coverage not approved.**	
8.	**Is the patient a candidate for systemic therapy or phototherapy?**	☐ Yes proceed to question **12**	☐ No **STOP** **Coverage not approved**
9.	**Does the patient have evidence of elevated CRP and/or MRI evidence of sacroiliitis AND an Ankylosing Spondylitis Disease Score (ASDAS) greater than or equal to 2.1?**	☐ Yes proceed to question **11**	☐ No **STOP** **Coverage not approved**
10.	**Has the patient had an inadequate response to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [e.g. sulfasalazine, mesalamine], corticosteroids, immunosuppressants [e.g. azathioprine], etc.)**	☐ Yes proceed to question **12**	☐ No **STOP** **Coverage not approved**
11.	**Has the patient had an inadequate response to at least two NSAIDS over a period of at least two months?**	☐ Yes proceed to question **12**	☐ No **STOP** **Coverage not approved**
12.	**Does the patient have evidence of a negative TB test result in the past 12 months (or TB is adequately managed)?**	☐ Yes proceed to question **13**	☐ No **STOP** **Coverage not approved**
13.	**Will the patient be receiving other targeted immunomodulatory biologics with Cimzia, including but not limited to the following: Actemra, Cosentyx, Enbrel, Humira, Ilumya, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Rituxan, Siliq, Simponi, Stelara, Taltz, Tremfya or Xeljanz/Xeljanz XR?**	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[3 February 2020]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: