Cimzia

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Drug Information:

*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un

*Directions(sig)*_____ *Route of administration*_____

*Dosing frequency*_____

Site of Service Questions:

A. Indicate the site of service requested:
- ❑ On Campus Outpatient Hospital (22)
- ❑ Off Campus Outpatient Hospital (19)
- ❑ Home (12), *skip to Criteria Questions*
- ❑ Office (11), *skip to Criteria Questions*
- ❑ Ambulatory Surgical Center (24), *skip to Criteria Questions*

B. Is the patient less than 18 years of age?
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No

C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre- medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

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D. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. Has the patient's home been deemed not eligible or appropriate for home infusion services by a home infusion provider? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

H. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?
ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation. ❑ Yes ❑ No

Clinical Criteria Questions:

1. What is the prescribed dose and frequency?
   a) **Loading dose:**
   ❑ Cimzia Starter Kit Quantity and Frequency: _____
   ❑ Cimzia 200 mg PFS (prefilled syringe) Quantity and Frequency: _____
   ❑ Cimzia Kit (lyophilized powder - vial) Quantity and Frequency: _____
   ❑ Other _____

   b) **Maintenance dose:**
   ❑ Cimzia 200 mg PFS (prefilled syringe) Quantity and Frequency: _____
   ❑ Cimzia Kit (lyophilized powder - vial) Quantity and Frequency: _____
   ❑ Other _____

2. Has the patient been diagnosed with any of the following?
   ❑ Moderately to severely active rheumatoid arthritis (RA)
   ❑ Active psoriatic arthritis WITH co-existent plaque psoriasis (PsA)
   ❑ Active psoriatic arthritis WITHOUT co-existent plaque psoriasis (PsA)
   ❑ Moderately to severely active Crohn's disease (CD)
   ❑ Active ankylosing spondylitis (AS)
   ❑ Active axial spondyloarthritis
   ❑ Moderate to severe plaque psoriasis
   ❑ Other ___

3. What is the ICD-10 code? ____

4. What is the patient's weight?_kg/lbs ***(circle one)***

Section A: All Requests

5. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic disease-modifying anti-rheumatic drug (DMARD) (e.g., Olumiant, Otezla, Xeljanz)?
   ❑ Yes ❑ No

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6. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic DMARD (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis? *If Yes, skip to #8*
❑ Yes ❑ No

7. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [PPD], interferon-release assay [IGRA], chest x-ray) within 6 months of initiating therapy? *If Yes, skip to #10* ❑ Yes ❑ No

8. Does the patient have risk factors for tuberculosis (TB) (e.g., persons with close contact to people with infectious TB disease; persons who have recently immigrated from areas of the world with high rates of TB [e.g., Africa, Asia, Eastern Europe, Latin America, Russia]; children less than 5 years of age who have a positive TB test; groups with high rates of TB transmission [e.g., homeless persons, injection drug users, persons with HIV infection], or persons who work or reside with people who are at an increased risk for active TB [e.g., hospitals, long-term care facilities, correctional facilities, homeless shelters])?
❑ Yes ❑ No *If No, skip to #13*

9. Has the patient been tested for tuberculosis (TB) within the previous 12 months? ❑ Yes ❑ No

10. What were the results of the tuberculosis (TB) test?
❑ Positive for TB ❑ Negative for TB, *skip to #13* ❑ Unknown

11. Does the patient have latent or active tuberculosis (TB)? ❑ Latent ❑ Active ❑ Unknown

12. Has treatment for latent tuberculosis (TB) infection been initiated or completed?
❑ Yes – treatment initiated ❑ Yes – treatment completed ❑ No

13. Is this request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to diagnosis section.*

14. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? ❑ Yes ❑ No ❑ Unknown *If Yes, or unknown, skip to diagnosis section*

15. Has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms since starting treatment with the requested drug?
❑ Yes ❑ No

Complete the following section based on the patient's diagnosis, if applicable.

Section B: Rheumatoid Arthritis

Continuation

16. Has the patient achieved or maintained positive clinical response since starting treatment with the requested drug?
❑ Yes ❑ No

17. What is the percent of disease activity improvement from baseline in tender joint count, swollen joint count, pain, or disability? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response and no further questions. _____%***

Initiation

18. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic DMARD (e.g., Rinvoq, Xeljanz) indicated for moderately to severely active rheumatoid arthritis?
If Yes, no further questions. ❑ Yes ❑ No

19. Does the patient meet BOTH of the following: a) the patient was tested for the rheumatoid factor (RF) biomarker AND b) the RF biomarker test was positive? ***ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing and skip to #26.***
❑ Yes ❑ No

20. Does the patient meet BOTH of the following: a) the patient was tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker AND b) the anti-CCP biomarker test was positive? ***ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing and skip to #26.***
❑ Yes ❑ No

21. Has the patient been tested for the rheumatoid factor (RF) biomarker? ***ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing.*** ❑ Yes ❑ No

22. Has the patient been tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker? ***ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing*** ❑ Yes ❑ No

23. Has the patient been tested for the C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR) biomarker(s)? ***ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing*** ❑ Yes ❑ No

24. Please indicate if the patient tested positive or negative for the C-reactive protein (CRP) biomarker, or if the test was not completed.
❑ Positive for CRP ❑ Negative for CRP ❑ Test for CRP was not completed

25. Please indicate if the patient tested positive or negative for the erythrocyte sedimentation rate (ESR) biomarker, or if the test was not completed.
❑ Positive for ESR ❑ Negative for ESR ❑ Test for ESR was not completed

26. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate at a dose greater than or equal to 20 mg per week? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and no further questions.*** ❑ Yes ❑ No

27. Has the patient experienced an intolerance to methotrexate? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and no further questions.*** ❑ Yes ❑ No

28. Does the patient have a contraindication to methotrexate? ❑ Yes ❑ No
ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy and indicate the contraindication: _____

Section C: Ankylosing Spondylitis or Axial Spondyloarthritis

Continuation

29. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response and no further questions.***
❑ Functional status ❑ Total spinal pain
❑ Inflammation (e.g., morning stiffness) ❑ None of the above

Initiation

30. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for active ankylosing spondylitis? ***ACTION REQUIRED: If 'Yes', please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.*** ❑ Yes ❑ No

31. Has the patient experienced an inadequate response with at least TWO nonsteroidal anti-inflammatory drugs (NSAIDs), or has an intolerance or contraindication to at least two NSAIDs? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. If therapy is if not advisable, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

Section D: Crohn's Disease

32. Has the patient achieved or maintained remission? ***ACTION REQUIRED: If 'Yes', please attach chart notes or medical record documentation of remission and no further questions.*** ❑ Yes ❑ No

Continuation

33. Which of the following has the patient experienced an improvement in from baseline***?*** ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response to therapy and no further questions.***
    - ❑ Abdominal pain or tenderness
    - ❑ Diarrhea
    - ❑ Body weight
    - ❑ Abdominal mass
    - ❑ Hematocrit
    - ❑ Endoscopic appearance of the mucosa
    - ❑ Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index [CDAI] score)
    - ❑ None of the above

Initiation

34. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for moderately to severely active Crohn's disease? ***ACTION REQUIRED: If 'Yes', attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.***
    ❑ Yes ❑ No

35. Does the patient have fistulizing disease? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting diagnosis and no further questions.*** ❑ Yes ❑ No

36. Has the patient tried and had an inadequate response to at least one conventional therapy option? ***ACTION REQUIRED: If 'Yes', please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and no further questions.***
    - ❑ Yes - Sulfasalazine (Azulfidine, Sulfazine) ❑ Yes - Budesonide (Entocort EC)
    - ❑ Yes - Mercaptopurine (Purinethol) ❑ Yes - Azathioprine (Azasan, Imuran)
    - ❑ Yes - Metronidazole (Flagyl) ❑ Yes - Methotrexate IM or SC
    - ❑ Yes - Ciprofloxacin (Cipro) ❑ Yes - Methylprednisolone (Solu-Medrol)
    - ❑ Yes - Prednisone ❑ Yes - Rifaximin (Xifaxan)
    - ❑ Yes - Tacrolimus ❑ No

37. Does the patient have a contraindication or intolerance to at least one conventional therapy option (e.g., azathioprine [Azasan, Imuran], budesonide [Entocort EC], ciprofloxacin [Cipro], mercaptopurine [Purinethol], methylprednisolone [Solu-Medrol], methotrexate IM or SC, metronidazole [Flagyl], prednisone, sulfasalazine [Azulfidine, Sulfazine], rifaximin [Xifaxan], tacrolimus)? ***ACTION REQUIRED:***
    If 'Yes', please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy. ❑ Yes ❑ No

Section E: Psoriatic Arthritis

Continuation

38. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response***. ***Please select all that apply***

- ❑ Number of swollen joints
- ❑ Number of tender joints
- ❑ Dactylitis
- ❑ Enthesitis
- ❑ Skin and/or nail involvement
- ❑ None of the above

Section F: Plaque Psoriasis

Continuation

39. Has the patient experienced a reduction in body surface area (BSA) affected from baseline? ***ACTION REQUIRED: If 'Yes', please attach chart notes or medical record documentation of decreased body surface area affected and no further questions.*** ❑ Yes ❑ No

40. Has the patient experienced an improvement in signs and symptoms of the condition from baseline (e.g., itching, redness, flaking, scaling, burning, cracking, pain)? ***ACTION REQUIRED: If 'Yes', please attach chart notes or medical record documentation of improvement in signs and symptoms.*** ❑ Yes ❑ No

Initiation

41. Has the patient ever received (including current utilizers) Otezla or a biologic (e.g., Humira) indicated for the treatment of moderate to severe plaque psoriasis? ***ACTION REQUIRED: If 'Yes', attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions…*** ❑ Yes ❑ No

42. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? ***ACTION REQUIRED: If 'Yes', please attach chart notes or medical record documentation of affected areas and body surface area affected and no further questions.*** ❑ Yes ❑ No

43. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)?

    ACTION REQUIRED: Please attach chart notes or medical record documentation of affected areas and body surface area affected. _____% *If greater than or equal to 10% of BSA, no further questions.*

44. Has the patient experienced an inadequate response, or has an intolerance to phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine or acitretin? ***ACTION REQUIRED: If 'Yes', please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

45. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine and acitretin? ***ACTION REQUIRED: If 'Yes', please attach documentation of clinical reason to avoid therapy*** ❑ Yes ❑ No
    If Yes, indicate the clinical reason: _____

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Priority Partners Fax: 1-866-212-4756