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 are accessible on the Department's Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

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

CLINICAL INFORMATION

Product requested: ☐Cimzia 200 mg vial kit ☐Cimzia 200 mg/ml syringe kit ☐Cimzia 200 mg/ml starter syringe kit			
Directions:	Quantity:	Refills:	Recipient's weight: _____ lbs/kg
Diagnosis (*submit documentation*):			Diagnosis code (*required*):

ALL requests

1. **Specialty Pharmacy Drug Program:** What Specialty Pharmacy will be used? ☐Diplomat Specialty ☐Walgreens Specialty
2. Check all that apply to the Recipient and *submit documentation for each*.
   - ☐screened for hepatitis B (antibody and/or surface antigen)
   - ☐screened for tuberculosis
   - ☐up-to-date with all age-appropriate immunizations (if < 21 years of age, in accordance with EPSDT guidelines)

INITIAL requests – complete questions applicable to Recipient's diagnosis

3. ***Ankylosing spondylitis or psoriatic arthritis*:** Does the Recipient have a history of trial and failure, contraindication, or intolerance of the following? ☐six-week trial each of at least 2 different NSAIDs ☐three-month trial of methotrexate or other DMARD	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
4. ***Ankylosing spondylitis, psoriatic arthritis, or rheumatoid arthritis*:** Does the Recipient 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.*
5. ***Ankylosing spondylitis, psoriatic arthritis, or rheumatoid arthritis*:** Does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred agents? *Check all that apply.* ☐Enbrel ☐Humira	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
6. ***Crohn's disease:*** Does the Recipient 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.*
7. ***Crohn's disease:*** Does the Recipient 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.*

All other diagnoses: *Submit documentation supporting the use of the requested medication for the Recipient's diagnosis.*

RENEWAL requests

1. Since starting Cimzia, has the Recipient experienced 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**:

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