SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Cimzia™ SQ (certolizumab) **(Prefilled syringe) (Pharmacy)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Cimzia™ is available under both Medical and Pharmacy benefits

DIAGNOSIS	Recommended Dose
❑ **Moderate to Severe Chronic Plaque Psoriasis**	• 400 mg (given as 2 subcutaneous injections of 200 mg each) initially weeks 0, 2 and 4. • 200 mg every other week or 400 mg every 4 weeks. • Six syringes/vials allowed in the initial 28 days • Two syringes/vials per 28 days for maintenance
❑ **Crohn's Disease – Moderate to Severe Active**	• 400 mg initially at weeks 0, 2 and 4 • If response occurs, follow with 400 mg every four weeks • Six syringes/vials allowed in the initial 28 days • Two syringes/vials per 28 days after induction period

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DIAGNOSIS	Recommended Dose
❑ **Rheumatoid Arthritis – Moderate to Severe**	• 400 mg initially at weeks 0, 2 and 4 • Followed by 200 mg every other week • Six syringes/vials allowed in the initial 28 days • Two syringes/vials per 28 days after induction period
❑ **Psoriatic Arthritis**	• 400 mg initially at weeks 0, 2 and 4 • 200 mg every other week; for maintenance dosing, or 400 mg every 4 weeks • Six syringes/vials allowed in the initial 28~~54~~ days • Two syringes/vials per 28 days for maintenance
❑ **Ankylosing Spondylitis**	• 400 mg (given as 2 subcutaneous injections of 200 mg each) initially weeks 0, 2 and 4 • 200 mg every other week or 400 mg every 4 weeks. • Six syringes/vials allowed in the initial 28 days • Two syringes/vials per 28 days for maintenance
❑ **Non-Radiographic Axial Spondyloarthritis (nr-axSpA)**	• 400 mg (given as 2 subcutaneous injections of 200 mg each) initially weeks 0, 2 and 4 • 200 mg every other week or 400 mg every 4 weeks. • Six syringes/vials allowed in the initial 28 days • Two syringes/vials per 28 days for maintenance
❑ **Polyarticular Juvenile Idiopathic Arthritis (pJIA)**	• **10 to < 20kg:** Loading: 100mg weeks 0, 2 and 4 Maintenance: 50mg every 2 weeks • **20 to < 40kg:** Loading: 200mg weeks 0, 2 and 4 Maintenance: 100mg every 2 weeks • **>40kg:** Loading: 400mg (administered as two 200mg injections) weeks 0, 2 and 4 Maintenance: 200mg every 2 weeks

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ Diagnosis: Moderate to Severe Chronic Plaque Psoriasis

- ❑ Member has moderate to severe plaque psoriasis who are candidates for systemic therapy or phototherapy
- ❑ Have not responded adequately to a trial of topical agents (e.g., anthralin, coal tar preparations, corticosteroids, emollients, immunosuppressives, keratolytics, retinoic acid derivatives, and/or Vitamin D analogues)
- ❑ Trial and failure of **TWO (2)** of the **PREFERRED**:

❑ Humira®	❑ Enbrel®	❑ Infliximab

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❑ Diagnosis: Crohn's Disease – Moderate to Severe Active

- ❑ Member has trial and failure of a compliant regimen of oral corticosteroids (budesonide 9mg daily for 8 weeks) or high dose steroids (40-60 mg prednisone) (moderate to severe CD) unless contraindicated or intravenous corticosteroids (severe and fulminant CD or failure to respond to oral corticosteroids)
- ❑ Member has trial and failure of a compliant regimen of azathioprine or mercaptopurine for three consecutive months
- ❑ Member has trial and failure of a compliant regimen of methotrexate for three consecutive months
- ❑ Member has tried and failed:

❑ Humira®	❑ Infliximab

❑ Diagnosis: Rheumatoid Arthritis – Moderate to Severe

- ❑ Trial and failure of, contraindication, or adverse reaction to methotrexate
- ❑ Trial and failure of **at least <u>ONE (1) other DMARD</u>** (**check each tried**):

❑ auranofin	❑ azathioprine	❑ leflunomide
❑ hydroxychloroquine	❑ sulfasalazine	

- ❑ Trial and failure of **<u>TWO (2)</u>** of the **<u>PREFERRED</u>** drugs below:

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ Diagnosis: Psoriatic Arthritis

- ❑ Trial and failure of methotrexate **<u>OR</u>** requested medication will be used in conjunction with methotrexate

OR

- ❑ Member has a contraindication to methotrexate (e.g., alcohol abuse, cirrhosis, chronic liver disease, or other contraindication)
- ❑ Trial and failure of **<u>TWO (2)</u>** of the **<u>PREFERRED</u>** drugs below:

❑ Humira®	❑ Enbrel®	❑ Infliximab

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❑ Diagnosis: Ankylosing Spondylitis

- ❑ Trial and failure of at least **two (2) NSAIDS**

OR

- ❑ Use of NSAIDs is contraindicated in member
- ❑ Trial and failure of **TWO (2)** of the **PREFERRED** drugs below:

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ Diagnosis: Non-Radiographic Axial Spondyloarthritis

- ❑ Member has a diagnosis of Active Non-radiographic Axial Spondyloarthritis (nr-axSpA)
- ❑ Trial and failure of **BOTH** of the **PREFERRED** drugs below:

❑ Humira®	❑ Infliximab

❑ Diagnosis: Polyarticular Juvenile Idiopathic Arthritis (pJIA)

- ❑ Trial and failure of methotrexate **OR** requested medication will be used in conjunction with methotrexate

OR

- ❑ Member has a contraindication to methotrexate
- ❑ Trial and failure of **BOTH** of the **PREFERRED** drugs below:

❑ Humira®	❑ Enbrel®

Medication being provided by (check applicable box(es) below):

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy – PropriumRx**

Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

REVISED/REFORMATTED/UPDATED: ~~4/6/2018; 10/28/2018; 11/18/2018; 12/13/2018; (Rev) 4/5/2019; 12/17/2019; 11/23/2020; 6/28/2021; 01/05/2022; 1/6/2022; 6/28/202206/23/2023; 11/8/2023, 12/3/2024~~**, 12/13/2024**