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™ (certolizumab) **Lyophilized (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
(Please select appropriate PA form)

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 is 18 years of age or older
- ❑ Member has moderate to severe plaque psoriasis who are candidates for systemic therapy or phototherapy
- ❑ Member must have a previous failure on a topical psoriasis agent
- ❑ Trial and failure of **TWO (2)** of the preferred drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Enbrel®	❑ Pyzchiva® syringe/vial **OR** Starjemza™ (Requires trial and failure of a preferred TNF-alpha inhibitor)

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

- ❑ Member is 18 years of age or older
- ❑ Member has trial and failure of a compliant regimen of corticosteroids or immunomodulators (e.g. azathioprine, 6-mercaptopurine, or methotrexate)
- ❑ Member has tried and failed **BOTH** of the preferred drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Pyzchiva® syringe/vial **OR** Starjemza™ (Requires trial and failure of a preferred TNF-alpha inhibitor)

❑ Diagnosis: Rheumatoid Arthritis – Moderate to Severe

- ❑ Member is 18 years of age or older
- ❑ Trial and failure of one conventional synthetic disease modifying anti-rheumatic drug (csDMARD) (e.g. methotrexate, azathioprine, hydroxychloroquine, penicillamine, sulfasalazine, leflunomide, etc.)
- ❑ Trial and failure of **BOTH** of the preferred drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Enbrel®

❑ Diagnosis: Psoriatic Arthritis

- ❑ Member is 18 years of age or older
- ❑ Trial and failure of **TWO (2)** of the preferred drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Enbrel®	❑ Pyzchiva® syringe/vial **OR** Starjemza™ (Requires trial and failure of a preferred TNF-alpha inhibitor)

❑ Diagnosis: Ankylosing Spondylitis

- ❑ Member is 18 years of age or older
- ❑ Trial and failure of an adequate trial of at least **two (2) NSAIDS OR**
- ❑ Use of NSAIDs is contraindicated in member
- ❑ Trial and failure of **BOTH** of the preferred drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Enbrel®

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❑ Diagnosis: Active Non-Radiographic Axial Spondyloarthritis

- ❑ Member is 18 years of age or older
- ❑ Member has a diagnosis of Active Non-radiographic Axial Spondylarthritis (nr-axSpA) with objective signs of inflammation

❑ Diagnosis: Polyarticular Juvenile Idiopathic Arthritis (pJIA)

- ❑ Member is 2 years of age or older
- ❑ Trial and failure of either oral non-steroidal anti-inflammatory drugs (NSAIDs) OR one conventional synthetic disease modifying anti-rheumatic drug (csDMARD) (e.g. methotrexate, azathioprine, hydroxychloroquine, penicillamine, sulfasalazine, leflunomide, etc.)
- ❑ Trial and failure of **BOTH** of the preferred drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ 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/UPDATED/REFORMATTED: ~~1/1/2017; 4/30/2018; 8/17/2018; 10/8/2018; 11/24/2018; 4/9/2019; 4/11/2019; 4/26/2019; 5/7/2019; 7/22/2019; 10/16/2019; 10/16/2020; 7/19/2021; 8/10/2021; 6/28/2022;6/23/2023; 10/25/2023, 12/3/2024, 12/13/2024, 1/22/2025; 10/17/2025; 12/12/2025; 1/20/2026, 2/23/2026, 3/6/2026;~~ **7/9/2026**