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:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Weight: _____ **Date:** _____

- **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
❑ **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

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DIAGNOSIS	Recommended Dose
❑ **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

CLINCIAL 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.

Prescriber is: ❑ **Gastroenterologist** ❑ **Rheumatologist** ❑ **Dermatologist**

❑ **Diagnosis: Moderate to Severe Chronic Plaque Psoriasis**

❑ Member has moderate to severe plaque psoriasis who are candidates for systemic therapy or phototherapy

AND

❑ 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)

AND

❑ Have not responded adequately to a 3-month minimum trial of phototherapy (e.g. Psoralens with UVA light (PUVA) OR UVB with coal tar or dithranol)

AND

❑ 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)

AND

- ❑ Member tried and failed **at least ONE previous 5-Aminosalicylates or immunomodulator therapy below:**

❑ methotrexate	❑ azathioprine	❑ auranofin
❑ sulfasalazine	❑ oral aminosalicylates	❑ leflunomide
❑ 6-mercaptopurine	❑ Apriso®	❑ balsalazide
❑ Pentasa®		

AND

- ❑ Member has tried and failed:

❑ Humira®	❑ Infliximab

❑ Diagnosis: Rheumatoid Arthritis – Moderate to Severe

- ❑ Trial and failure of, contraindication, or adverse reaction to methotrexate

AND

- ❑ Trial and failure of **at least ONE (1) other DMARD** (**check each tried**):

❑ auranofin	❑ azathioprine	❑ leflunomide
❑ hydroxychloroquine	❑ sulfasalazine	

AND

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

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ Diagnosis: Psoriatic Arthritis

- ❑ Trial and failure of methotrexate

OR

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- ❑ 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);

AND

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

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ Diagnosis: Ankylosing Spondylitis

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

OR

- ❑ Use of NSAIDs is contraindicated in member

AND

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

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ Diagnosis: A Non-Radiographic Axial Spondyloarthritis

- ❑ Member has a diagnosis of Active Non-radiographic Axial Spondylarthritis (nr-axSpA)

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.