

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
(Please select appropriate PA form)**

DIAGNOSIS	Recommended Dose
<input type="checkbox"/> Moderate to Severe Chronic Plaque Psoriasis	<ul style="list-style-type: none">• 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
<input type="checkbox"/> Crohn's Disease – Moderate to Severe Active	<ul style="list-style-type: none">• 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
<input checked="" type="checkbox"/> Rheumatoid Arthritis – Moderate to Severe	<ul style="list-style-type: none"> • 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
<input checked="" type="checkbox"/> Psoriatic Arthritis	<ul style="list-style-type: none"> • 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 days • Two syringes/vials per 28 days for maintenance
<input checked="" type="checkbox"/> Ankylosing Spondylitis	<ul style="list-style-type: none"> • 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
<input checked="" type="checkbox"/> Non-Radiographic Axial Spondyloarthritis (nr- axSpA)	<ul style="list-style-type: none"> • 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
<input checked="" type="checkbox"/> Polyarticular Juvenile Idiopathic Arthritis (pJIA)	<ul style="list-style-type: none"> • 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

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Trial and failure of **TWO (2)** of the preferred drugs below:

<input type="checkbox"/> adalimumab-adbm (Boehringer Ingelheim) OR Hadlima® (adalimumab-bwwd)	<input type="checkbox"/> Enbrel®	<input type="checkbox"/> Pyzchiva® <u>syringe/vial</u> (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 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 **BOTH** of the preferred drugs below:

<input type="checkbox"/> adalimumab-adbm (Boehringer Ingelheim) OR Hadlima® (adalimumab-bwwd)	<input type="checkbox"/> Pyzchiva® <u>syringe/vial</u> (Requires trial and failure of a preferred TNF-alpha inhibitor)
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Diagnosis: Rheumatoid Arthritis – Moderate to Severe

- Member is 18 years of age or older
- Trial and failure of, contraindication, or adverse reaction to methotrexate
- Trial and failure of **at least ONE (1) other DMARD (check each tried):**

<input type="checkbox"/> auranofin	<input type="checkbox"/> azathioprine	<input type="checkbox"/> leflunomide
<input type="checkbox"/> hydroxychloroquine	<input type="checkbox"/> sulfasalazine	

- Trial and failure of **BOTH** of the preferred drugs below:

<input type="checkbox"/> adalimumab-adbm (Boehringer Ingelheim) OR Hadlima® (adalimumab-bwwd)	<input type="checkbox"/> Enbrel®
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Diagnosis: Psoriatic Arthritis

- Member is 18 years of age or older
- Trial and failure of methotrexate **OR** requested medication will be used in conjunction with methotrexate **OR**

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

<input type="checkbox"/> adalimumab-adbm (Boehringer Ingelheim) OR Hadlima® (adalimumab-bwwd)	<input type="checkbox"/> Enbrel®	<input type="checkbox"/> Pyzchiva® syringe/vial (Requires trial and failure of a preferred TNF-alpha inhibitor)
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Diagnosis: Ankylosing Spondylitis

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

<input type="checkbox"/> adalimumab-adbm (Boehringer Ingelheim) OR Hadlima® (adalimumab-bwwd)	<input type="checkbox"/> Enbrel®
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Diagnosis: Non-Radiographic Axial Spondyloarthritis

- Member is 18 years of age or older
- Member has a diagnosis of Active Non-radiographic Axial Spondyloarthritis (nr-axSpA)

Diagnosis: Polyarticular Juvenile Idiopathic Arthritis (pJIA)

- Member is 2 years of age or older
- 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:

<input type="checkbox"/> adalimumab-adbm (Boehringer Ingelheim) OR Hadlima® (adalimumab-bwwd)	<input type="checkbox"/> Enbrel®
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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.