# SENTARA COMMUNITY PLAN
# (MEDICAID)

## MEDICAL 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 1-844-305-2331**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

**Drug Requested: Cimzia™** (certolizumab) **Lyophilized (J0717) (Medical)**

**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:** _____

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

**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.<br>• 200 mg every other week or 400 mg every 4 weeks.<br>• Six syringes/vials allowed in the initial 28 days<br>• Two syringes/vials per 28 days for maintenance |
| ❑ **Crohn's Disease – Moderate to Severe Active** | • 400 mg initially at weeks 0, 2 and 4<br>• If response occurs, follow with 400 mg every four weeks<br>• Six syringes/vials allowed in the initial 28 days<br>• 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<br>• Followed by 200 mg every other week<br>• Six syringes/vials allowed in the initial 28 days<br>• Two syringes/vials per 28 days after induction period |
| ❑ **Psoriatic Arthritis** | • 400 mg initially at weeks 0, 2 and 4<br>• 200 mg every other week; for maintenance dosing, or 400 mg every 4 weeks<br>• Six syringes/vials allowed in the initial 28~~54~~ days<br>• 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<br>• 200 mg every other week or 400 mg every 4 weeks.<br>• Six syringes/vials allowed in the initial 28 days<br>• 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<br>• 200 mg every other week or 400 mg every 4 weeks.<br>• Six syringes/vials allowed in the initial 28 days<br>• Two syringes/vials per 28 days for maintenance |
| ❑ **Polyarticular Juvenile Idiopathic Arthritis (pJIA)** | • **10 to < 20kg:** Loading: 100mg weeks 0, 2 and 4<br>Maintenance: 50mg every 2 weeks<br>• **20 to < 40kg:** Loading: 200mg weeks 0, 2 and 4<br>Maintenance: 100mg every 2 weeks<br>• **>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:

| | | |
|---|---|---|
| ❑ Humira® | ❑ Enbrel® | ❑ Infliximab |

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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:

| | |
|---|---|
| ❑ Humira® | ❑ Infliximab |

## ❑ 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**):

| | | |
|---|---|---|
| ❑ auranofin | ❑ azathioprine | ❑ leflunomide |
| ❑ hydroxychloroquine | ❑ sulfasalazine | |

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

| | | |
|---|---|---|
| ❑ Humira® | ❑ Enbrel® | ❑ Infliximab |

## ❑ 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**
- ❑ 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:

| | | |
|---|---|---|
| ❑ Humira® | ❑ Enbrel® | ❑ Infliximab |

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## ❑ 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 **TWO (2)** of the preferred drugs below:

| | | |
|---|---|---|
| ❑ Humira® | ❑ Enbrel® | ❑ Infliximab |

## ❑ 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)

## ❑ 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:

| | |
|---|---|
| ❑ Humira® | ❑ Enbrel® |

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

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

For urgent reviews: Practitioner should call Sentara Health Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

***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;06/23/2023; 10/25/2023, 12/3/2024, 12/13/2024, 1/22/2025;~~ **10/17/2025**