

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
<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 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 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 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 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 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:

❑ 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 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:

❑ adalimumab-adbm (Boehringer Ingelheim) OR Hadlima [®] (adalimumab-bwwd)	❑ Pyzchiva [®] syringe/vial OR Starjemza [™] (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):**

❑ auranofin	❑ azathioprine	❑ leflunomide
❑ hydroxychloroquine	❑ sulfasalazine	

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

❑ adalimumab-adbm (Boehringer Ingelheim) OR Hadlima [®] (adalimumab-bwwd)	❑ 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 OR Starjemza [™] (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 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:

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