Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Cimzia (certolizumab pegol) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 12 months

Instructions:
This form is used by Kaiser Permanente and/or participating providers for coverage of **Cimzia (certolizumab pegol).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete.**
KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: ______________________________ Kaiser Medical ID#: _________________ Date of Birth: _____________

2 – Prescriber Information

Is the prescriber a Rheumatologist, Dermatologist, or Gastroenterologist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: ____

Prescriber Name: ______________________________ Specialty: ____________________________ NPI: _________________

Prescriber Address: ____

Prescriber Phone #: __________________________Prescriber Fax #: ___________________________

Do you have an approved provider referral number from Kaiser Permanente?
□ Yes – please provide your provider referral number here: ________________

3 – Pharmacy Information

Pharmacy Name: ________________________________ Pharmacy NPI: ____

Pharmacy Phone #_______________________________ Pharmacy Fax #: ____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: ____
Sig: ____

Drug 2: Name/Strength/Formulation: ____
Sig: ____

5–Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: ___________________________________

2. Indicate the patient's diagnosis for the requested medication: ____

Clinical Criteria:

Rheumatology:

1. Does the patient have a diagnosis of rheumatoid arthritis, psoriatic arthritis, or spondyloarthropathy?
   □ No □ Yes

2. If of childbearing potential, is the patient pregnant, attempting to conceive, and/or breastfeeding?
   □ No □ Yes □ N/A, patient not of childbearing potential

3. Has the patient had an inadequate response, contraindication, or intolerance to at least one of the preferred anti-TNF agents [i.e. adalimumab-atto (Amjevita) or infliximab-dyyb (Inflectra)]?
   □ No □ Yes

Gastroenterology:

1. Does the patient have a diagnosis of Crohn's disease?
   □ No □ Yes

2. If of childbearing potential, is the patient pregnant, attempting to conceive, and/or breastfeeding?
   □ No □ Yes □ N/A, patient not of childbearing potential

3. Has the patient had an inadequate response, contraindication, or intolerance to at least one of the preferred anti-TNF agents [i.e. adalimumab-atto (Amjevita) or infliximab-dyyb (Inflectra)]?
   □ No □ Yes

For continuation of therapy, please respond to additional questions below:

1. If of childbearing potential, is the patient still pregnant, attempting to conceive, and/or breastfeeding?
   □ No □ Yes □ N/A, patient not of childbearing potential

2. Has the patient had a clinically significant benefit from medication (i.e. asymptomatic or in clinical remission)?
   □ No □ Yes

3. Has specialist follow-up occurred in the past 12 months since last review?
   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

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I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	Date:
Please Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is private and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. Please notify sender if document was not intended for receipt by your facility	