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

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Cimzia (certolizumab).** 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. The 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 – Provider Information

Provider Name: ________________________________ Specialty: ______________________ Provider NPI: ___________________

Provider Address: ____

Provider Phone #: ____________________________Provider Fax #: _____________________________

Please check the boxes that apply:

□ Initial Request □ Continuation of Therapy Request

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. Does the member have diagnosis of one of the following? AND

   □ Adult Moderate to severe Rheumatoid Arthritis (RA)

   □ Adult Crohn's disease (CD)

   □ Adult Psoriatic arthritis (PsA)

   □ Adult Ankylosing Spondylitis (AS)

   □ Adult Active Non-radiographic Axial Spondylarthritis (nr-axSpA)

   □ Adults Moderate-to-Severe plaque psoriasis who are candidates for systemic therapy or phototherapy

   □ Treatment of active polyarticular juvenile idiopathic arthritis (pJIA) for patients ≥ 2 yo.

   □ Other: ____________________

2. Was there therapeutic failure to one of the preferred agents? (e.g. Enbrel, Humira) AND

   □ No □ Yes

3. If this is being used for Active Non-radiographic Axial Spondylarthritis (nr-axSpA):
   a. Does the patient have objective signs of inflammation? AND
      □ No □ Yes

   b. Did the patient have and inadequate response, intolerance, or contraindication to at least TWO non-steroidal anti-inflammatory drugs (NSAIDs)?
      □ No □ Yes

4. If this is being used for Ankylosing spondylitis (AS):
   a. Did the patient try and fail (or have a contraindication to) an adequate trial of at least two NSAIDs?
      □ No □ Yes

5. For moderate to severe Crohn's Disease (CD):
   a. Did the patient try and fail (or have a contraindication to) a regimen of oral corticosteroids ? AND
      □ No □ Yes
      i. Were they compliant with therapy?
         □ No □ Yes

   b. For severe and fulminant CD or failure to respond to oral corticosteroids, did the patient try or fail (or have a contraindication to) intravenous corticosteroids? AND
      □ No □ Yes
      i. Were they compliant with therapy?
         □ No □ Yes

   c. Did the patient try and fail (or have a contraindication to) a regimen of azathioprine or mercaptopurine for three consecutive months? AND

      □ No □ Yes

i. Were they compliant with therapy?
□ No □ Yes

d. Did the patient try and fail (or have a contraindication to) a regimen of parenteral methotrexate for three consecutive months?
□ No □ Yes
i. Were they compliant with therapy?
□ No □ Yes

6. If this is being used for Psoriatic Arthritis (PsA):
a. Did the patient try and fail methotrexate? OR
□ No □ Yes

b. Does the patient have a contraindication to methotrexate? (e.g., alcohol abuse, cirrhosis, chronic liver disease, or other contraindication) OR
□ No □ Yes

c. Will the requested medication be used in conjunction with methotrexate?
□ No □ Yes

7. If this is being used for Rheumatoid Arthritis (RA):
a. Did the patient try and fail methotrexate? OR
□ No □ Yes

b. Does the patient have a contraindication to methotrexate? (e.g., alcohol abuse, cirrhosis, chronic liver disease, or other contraindication)? AND
□ No □ Yes

c. Did the patient try and fail another DMARD (other than methotrexate), such as azathioprine, d-penicillamine, cyclophosphamide, cyclosporine, gold salts, hydroxychloroquine, leflunomide, sulfasalazine, or tacrolimus?
□ No □ Yes

8. If this is being used for active polyarticular juvenile idiopathic arthritis (pJIA) for patients ≥ 2 years of age:

a. Did the patient try and fail methotrexate? OR
□ No □ Yes

b. Does the patient have a contraindication to methotrexate? OR,

□ No □ Yes

c. Is requested medication being used in conjunction with methotrexate?

□ No □ Yes

9. If this if being used for moderate-to-severe plaque psoriasis while candidates for systemic therapy or phototherapy:

a. Did the patient try and fail a topical psoriasis agent?

□ No □ Yes

6 – Provider 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.

Provider Signature:	**Date:**
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