



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
Cimzia (Medicare Determination)**

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at 1-888-836-0730.
Please contact CVS|Caremark at 1-800-294-5979 with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Cimzia (Medicare Determination).

Drug Name (select from list of drugs shown)

Cimzia (certolizumab pegol)

Patient Information

Patient

Name: _____

Patient ID: _____

Patient

Group No.: _____

Patient

DOB: _____

Prescribing Physician

Physician

Name: _____

Physician

Phone: _____

Physician

Fax: _____

Physician

Address: _____

City, State,

Zip: _____

Diagnosis: _____

ICD

Code: _____

Please circle the appropriate answer for each applicable question.

- | | | |
|--|---|---|
| 1. Is the physician purchasing and providing the drug "incidentto" physician services? | Y | N |
| 2. Has the patient previously received Cimzia through a CVS Caremark administered benefit for one of the following conditions?
•Crohn's Disease
•RA
[If no, then skip to question 4.] | Y | N |
| 3. Has the patient responded to Cimzia therapy (e.g., condition improved or stabilized)?
[If the answer is yes, skip to question 14.]
[If no, then no further questions are required.] | Y | N |
| 4. Is the patient 18 years of age or older?
[If no, then no further questions are required.] | Y | N |
| 5. Prior to initiating therapy, does the patient have a diagnosis of moderately to severely active RA as the reason to request Cimzia?
[If no, then skip to question 7.] | Y | N |



Arkansas BlueCross BlueShield

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|-----|--|---|---|
| 6. | Has the patient failed or inadequately responded to a nonbiologic DMARD or does the patient have an intolerance or contraindication to multiple nonbiologic DMARDs?
•Examples of nonbiologic DMARDs: MTX, leflunomide, hydroxychloroquine, sulfasalazine
[If yes, skip to question 9.]
[If no, then no further questions are required.] | Y | N |
| 7. | At the initiation of therapy, did the patient have a diagnosis of moderately to severely active Crohn's disease as the reason to request Cimzia?
[If no, then no further questions are required.] | Y | N |
| 8. | Did the patient have an inadequate response to conventional therapy for Crohn's disease (e.g., corticosteroids, sulfasalazine, azathioprine, or mesalamine) or to biologic agents such as Remicade or Humira?
[If no, then no further questions are required.] | Y | N |
| 9. | Prior to initiating therapy, did the patient have a TB skin test?
[If no, then no further questions are required.] | Y | N |
| 10. | Was the result of the TB test positive?
[If no, then skip to question 13.] | Y | N |
| 11. | Does the patient have active TB?
[If the answer is yes, then no further questions are required.] | Y | N |
| 12. | Is the patient receiving treatment for latent TB infection or has the patient completed treatment for latent TB infection prior to initiating Cimzia?
[If the answer is no, then no further questions are required.] | Y | N |
| 13. | Prior to initiating therapy, has the prescriber assessed the patient's risk of hepatitis B, and if appropriate ruled out or initiated treatment for hepatitis B?
[If the answer is no, then no further questions are required.] | Y | N |
| 14. | Prior to starting Cimzia (or to continue treatment with Cimzia), will the use of any other biologic DMARD be discontinued?
•Examples of biologic DMARDs: Enbrel, Humira, Kineret, Orencia, Remicade, Rituxan, Simponi, or Tysabri | Y | N |
| 15. | Does the patient have an active infection (chronic or localized)? | Y | N |

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date