

US Family Health Plan
 Prior Authorization Request Form for
 certolizumab (**Cimzia**)

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To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 Please complete patient and physician information (please print):

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID # _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

Step 2 Please complete the clinical assessment:

1. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	<input type="checkbox"/> Yes proceed to question 2	<input type="checkbox"/> No proceed to question 5
2. Does the patient have a diagnosis of treatment of adult patients with active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation?	<input type="checkbox"/> Yes proceed to question 7	<input type="checkbox"/> No proceed to question 3
3. Has the patient had an inadequate response to Humira?	<input type="checkbox"/> Yes proceed to question 7	<input type="checkbox"/> No proceed to question 4
4. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	<input type="checkbox"/> Yes proceed to question 7	<input type="checkbox"/> No STOP Coverage not approved
5. Does the patient have a diagnosis of treatment of adult patients with active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation?	<input type="checkbox"/> Yes proceed to question 7	<input type="checkbox"/> No proceed to question 6
6. Does the patient have a contraindication to Humira (adalimumab)?	<input type="checkbox"/> Yes proceed to question 7	<input type="checkbox"/> No STOP Coverage not approved
7. Cases of worsening congestive heart failure (CHF) and new onset CHF have been reported with TNF blockers, including CIMIZA. Is the prescriber aware of this?	<input type="checkbox"/> Yes proceed to question 8	<input type="checkbox"/> No STOP Coverage not approved
8. Is the patient 18 years of age or older?	<input type="checkbox"/> Yes proceed to question 9 on page 2	<input type="checkbox"/> No STOP Coverage not approved

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<p>9. What is the indication or diagnosis?</p>	<p><input type="checkbox"/> moderate to severe active rheumatoid arthritis – proceed to question 11</p> <p><input type="checkbox"/> active psoriatic arthritis – proceed to question 11</p> <p><input type="checkbox"/> active ankylosing spondylitis – proceed to question 12</p> <p><input type="checkbox"/> moderately to severely active Crohn's disease – proceed to question 11</p> <p><input type="checkbox"/> moderate to severe plaque psoriasis - proceed to question 10</p> <p><input type="checkbox"/> active non-radiographic axial spondyloarthritis with objective signs of inflammation - proceed to question 13</p> <p><input type="checkbox"/> other indication or diagnosis – STOP: coverage not approved.</p>	
<p>10. Is the patient a candidate for systemic therapy or phototherapy?</p>	<p><input type="checkbox"/> Yes proceed to question 13</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>11. Has the patient had an inadequate response to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [e.g. sulfasalazine, mesalamine], corticosteroids, immunosuppressants [e.g. azathioprine], etc.)</p>	<p><input type="checkbox"/> Yes proceed to question 13</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>12. Has the patient had an inadequate response to at least two NSAIDs over a period of at least two months?</p>	<p><input type="checkbox"/> Yes proceed to question 13</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>13. Does the patient have evidence of a negative TB test result in the past 12 months (or TB is adequately managed)?</p>	<p><input type="checkbox"/> Yes proceed to question 14</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>14. Will the patient be receiving other targeted immunomodulatory biologics with Cimzia, including but not limited to the following: Actemra, Cosentyx, Enbrel, Humira, Ilumya, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Rituxan, Siliq, Simponi, Stelara, Taltz, Tremfya or Xeljanz/Xeljanz XR?</p>	<p><input type="checkbox"/> Yes STOP Coverage not approved</p>	<p><input type="checkbox"/> No Sign and date below</p>

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

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Prescriber Signature

Date

[24 April 2019]