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

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 855-273-5735

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**

Prior authorization does not expire.

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?	☐ Yes proceed to question **2**	☐ No proceed to question **4**
2. Has the patient had an inadequate response to Humira?	☐ Yes proceed to question **5**	☐ No proceed to question **3**
3. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
4. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Is the patient 18 years of age or older?	☐ Yes proceed to question **9**	☐ No proceed to question **6**
6. Is the patient 2 years of age or older?	☐ Yes proceed to question **7**	☐ No **STOP** **Coverage not approved**

7. Is the requested medication being requested for the indication of Polyarticular Juvenile Idiopathic Arthritis (pJIA)?	☐ Yes proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Has the patient had an inadequate response to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [for example, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [for example, azathioprine], etc.)	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
9. What is the indication or diagnosis?	☐ moderate to severe active **rheumatoid arthritis** – proceed to question **10** ☐ active **psoriatic arthritis** – proceed to question **10** ☐ active **ankylosing spondylitis** – proceed to question **11** ☐ moderately to severely active **Crohn's disease** – proceed to question **12** ☐ moderate to severe **plaque psoriasis** in patients who are candidates for systemic therapy or phototherapy - proceed to question **10** ☐ active non-radiographic **axial spondyloarthritis** with objective signs of inflammation - proceed to question **11** ☐ other indication or diagnosis – **STOP: coverage not approved.**	
10. Has the patient had an inadequate response to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [for example, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [for example, azathioprine], etc.)	☐ Yes proceed to question **12**	☐ No **STOP** **Coverage not approved**
11. Has the patient had an inadequate response to at least two NSAIDS over a period of at least two months?	☐ Yes proceed to question **12**	☐ No **STOP** **Coverage not approved**

12. 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?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3

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

Prescriber Signature _____ Date _____

[09 Dec 2024]