Cimzia

Prior Authorization Request

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

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Exception Criteria Questions:

A. These are the preferred products for which coverage is provided for treatment of the following conditions:
- Rheumatoid arthritis, psoriatic arthritis: **Orencia, Remicade, and Simponi Aria**
- Plaque psoriasis, Crohn's disease, ulcerative colitis: **Remicade**
- Ankylosing spondylitis: **Remicade and Simponi Aria**
- Polyarticular juvenile idiopathic arthritis: **Orencia**

Can the patient's treatment be switched to a preferred product?
❑ Yes, *Please obtain Form for preferred product and submit for corresponding PA*.
❑ No

B. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No, *skip to Question D*

C. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? *If unknown, answer Yes*.
❑ Yes ❑ No, *skip to Clinical Criteria Questions*

D. Is the patient currently pregnant or breastfeeding? ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. What is the diagnosis?
❑ Rheumatoid Arthritis
❑ Crohn's disease, *skip to Question G.*
❑ Psoriatic arthritis
❑ Plaque psoriasis, *skip to Question G.*
❑ Ulcerative colitis, *skip to Clinical Criteria Questions.*
❑ Ankylosing spondylitis, *skip to Question I.*
❑ Polyarticular juvenile idiopathic arthritis, *skip to Clinical Criteria Questions.*
❑ Other, *skip to Clinical Criteria Questions*

F. Has the patient had a documented inadequate response or intolerable adverse event with all of the preferred products (Orencia, Remicade, and Simponi Aria)? **Action Required:** ***If 'Yes', attach supporting chart note(s).***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No *skip to Clinical Criteria Questions*

G. Has the patient had a documented inadequate response or intolerable adverse event with the preferred product (Remicade)? **Action Required:** ***If 'Yes', attach supporting chart note(s).***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

H. Does the patient have one of the following documented clinical reasons to avoid Remicade? *Indicate below and skip to Clinical Criteria Questions*. **Action Required:** ***If 'Yes', attach supporting chart note(s).***
❑ Yes – History of demyelinating disorder
❑ Yes – History of congestive heart failure
❑ Yes – History of hepatitis B virus infection
❑ Yes – Autoantibody formation/lupus-like syndrome
❑ Yes – Risk of lymphoma
❑ No

I. Has the patient experienced a documented inadequate response or intolerable adverse event with all preferred products (Remicade and Simponi Aria)? **Action Required:** ***If 'Yes', attach supporting chart note(s).***
❑ Yes ❑ No

Criteria Questions:

1. Has the patient been diagnosed with any of the following?
❑ Moderately to severely active rheumatoid arthritis (RA)
❑ Active psoriatic arthritis (PsA)
❑ Active ankylosing spondylitis (AS)
❑ Active axial spondyloarthritis
❑ Moderately to severely active Crohn's disease (CD)
❑ Other _____

2. What is the ICD-10 code? _____

3. Is this request for continuation of therapy? ❑ Yes ❑ No *If No, skip to #7*

4. Is the patient currently receiving Cimzia through samples or a manufacturer's patient assistance program?
❑ Yes ❑ No ❑ Unknown *If Yes or Unknown, skip to #7*

5. How long has the patient been receiving the requested medication? _____ months

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If less than 3 months, no further questions.

6. Has the patient achieved or maintained positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms? *If Yes, no further questions* ❑ Yes ❑ No

7. Has the patient received any of the following medications?
   If Yes, please indicate the most recent medication and skip to diagnosis section.
   ❑ Actemra ❑ Cosentyx ❑ Enbrel ❑ Entyvio ❑ Humira ❑ Inflectra ❑ Kevzara ❑ Kineret ❑ Orencia
   ❑ Remicade ❑ Renflexis ❑ Rituxan ❑ Siliq ❑ Simponi ❑ Simponi Aria ❑ Stelara ❑ Taltz ❑ Tremfya
   ❑ Tysabri ❑ Xeljanz ❑ Xeljanz XR ❑ No

8. Has the patient undergone pretreatment screening for latent tuberculosis (TB) infection with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB)? ❑ Yes ❑ No

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Rheumatoid Arthritis

9. Has the patient experienced an inadequate response after at least 3 months of treatment with the methotrexate dose greater than or equal to 20 mg per week? ❑ Yes ❑ No

10. Has the patient experienced intolerance to methotrexate? *If Yes, no further questions* ❑ Yes ❑ No

11. Does the patient have a contraindication to methotrexate? ❑ Yes ❑ No
    If Yes, indicate the contraindication: _____

Section B: Ankylosing Spondylitis or Axial Spondyloarthritis

12. Has the patient experienced an inadequate response with at least TWO nonsteroidal anti-inflammatory drugs (NSAIDs), or has an intolerance or contraindication to at least two NSAIDs? ❑ Yes ❑ No

Section C: Crohn's Disease

13. Has the patient tried and had an inadequate response to at least one conventional therapy option?
    If Yes, indicate below and no further questions.
    ❑ Yes - Sulfasalazine (Azulfidine, Sulfazine)
    ❑ Yes - Mesalamine, oral (Asacol, Pentasa, Delzicol, Lialda)
    ❑ Yes - Metronidazole (Flagyl)
    ❑ Yes - Ciprofloxacin (Cipro)
    ❑ Yes - Prednisone
    ❑ Yes - Budesonide (Entocort EC)
    ❑ Yes - Azathioprine (Azasan, Imuran)
    ❑ Yes - Mercaptopurine (Purinethol)
    ❑ Yes - Methotrexate
    ❑ Yes - Methylprednisolone (Solu-Medrol)
    ❑ Yes - Rifaximin (Xifaxan)
    ❑ No

14. Does the patient have a contraindication or intolerance to at least one conventional therapy option (e.g., azathioprine [Azasan, Imuran], budesonide [Entocort EC], ciprofloxacin [Cipro], mesalamine [Asacol, Delzicol, Pentasa, Lialda], mercaptopurine [Purinethol], methylprednisolone [Solu-Medrol], methotrexate, metronidazole [Flagyl], prednisone, sulfasalazine [Azulfidine, Sulfazine], rifaximin [Xifaxan])? ❑ Yes ❑ No

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Step Therapy Override: Complete if Applicable.	Please Circle	
Would the prescriber like to request an override of the step therapy requirement?	Yes	No
Has the member received the medication through a pharmacy or medical benefit within the past 180 days? ***Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.)***	Yes	No
Is the medication effective in treating the member's condition?	Yes	No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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