Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Cimzia (certolizumab pegol) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 12 months

Instructions:

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

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 – Prescriber Information

Is the prescriber a Rheumatologist, Dermatologist, or Gastroenterologist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

Do you have an approved provider referral number from Kaiser Permanente?
□ Yes – please provide your provider referral number here: _____

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. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

Rheumatology:

1. Does the patient have a diagnosis of rheumatoid arthritis, psoriatic arthritis, or spondyloarthropathy?
   □ No □ Yes

2. If of childbearing potential, is the patient pregnant, attempting to conceive, and/or breastfeeding?
   □ No □ Yes □ N/A, patient not of childbearing potential

3. Has the patient had an inadequate response, contraindication, or intolerance to at least one of the preferred anti-TNF agents [i.e. adalimumab-atto (Amjevita) or infliximab-dyyb (Inflectra)]?
   □ No □ Yes

Gastroenterology:

1. Does the patient have a diagnosis of Crohn's disease?
   □ No □ Yes

2. If of childbearing potential, is the patient pregnant, attempting to conceive, and/or breastfeeding?
   □ No □ Yes □ N/A, patient not of childbearing potential

3. Has the patient had an inadequate response, contraindication, or intolerance to at least one of the preferred anti-TNF agents [i.e. adalimumab-atto (Amjevita) or infliximab-dyyb (Inflectra)]?
   □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below:

1. If of childbearing potential, is the patient still pregnant, attempting to conceive, and/or breastfeeding?
   □ No □ Yes □ N/A, patient not of childbearing potential

2. Has the patient had a clinically significant benefit from medication (i.e. asymptomatic or in clinical remission)?
   □ No □ Yes

3. Has specialist follow-up occurred in the past 12 months since last review?
   □ No □ Yes

6 – Prescriber 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:**

_____

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**

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