

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: <u>1-866-331-2104</u>]. If you have any questions or concerns, please call <u>1-866-331-2103</u>. 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:				

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	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:		
Cli	Clinical Criteria:		
	eumatology:		
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? \Box No \Box Yes \Box 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		
Ga	stroenterology:		
	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? \Box No \Box Yes \Box 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		
Fo	r 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? \Box No \Box Yes \Box 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)? \Box No \Box Yes		
3.	Has specialist follow-up occurred in the past 12 months since last review? □ No □ Yes		
6 – Prescriber Sign-Off			
	ditional Information –		
	Please submit chart notes/medical records for the patient that are applicable to this request. 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:		
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ı	I certify that the information provided is accurate. Supporting documentation is available for State audits.		

Prescriber Signature:	Date:
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