



Health Partners Plans

**HEALTH PARTNERS PLANS  
PRIOR AUTHORIZATION REQUEST FORM**

Cimzia® (certolizumab pegol)

Phone: 215-991-4300

Fax back to: 866-240-3712

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

Patient Name:	Prescriber Name:
HPP Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Address:	NPI: Promise ID:
City, State ZIP:	Prescriber PA PROMISE ID:
Patient Primary Phone:	Address:
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	City, State ZIP: <b>Specialty/facility name (if applicable):</b>

Expedited/Urgent

**Drug Name:**

**Strength:**

**Days Supply:**

**Number of Refills:**

**Directions / SIG:**

*HPP's maximum approval time is 12 months but may be less depending on the drug.*

**Please attach any pertinent medical history including labs and information for this member that may support approval.**

**Please answer the following questions and sign.**

Q1. Is the patient 18 years of age and has a diagnosis of moderately- to severely-active rheumatoid arthritis?

Yes                            No

Q2. Is the prescriber a rheumatologist or in consultation with a rheumatologist?

Yes                            No

Q3. Has patient failed or had an inadequate response to at least one DMARD, or have contraindications or intolerances to DMARDs (such as sulfasalazine, leflunomide, hydroxychloroquine, methotrexate)?

Yes                            No

Q4. Has the patient failed, had an inadequate response, or is there any contraindication for patient to try Enbrel and Humira OR has the patient been currently established on therapy with Cimzia (within the last 90 days)?

Yes                            No

Q5. Is the patient 18 years of age and has a diagnosis of Crohn's disease?

Yes                            No

Q6. Is the prescriber a gastroenterologist or in consultation with a gastroenterologist?

Yes                            No

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document.



Health Partners Plans

**HEALTH PARTNERS PLANS  
PRIOR AUTHORIZATION REQUEST FORM**

Cimzia® (certolizumab pegol)

Phone: 215-991-4300

Fax back to: 866-240-3712

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

Patient Name:

Prescriber Name:

Q7. Has the patient failed or had an inadequate response to at least one corticosteroid, or have contraindications or intolerances to corticosteroids?

Yes

No

Q8. Has the patient failed or had an inadequate response to at least one of the following, or have contraindications or intolerances to: azathioprine (Imuran), 6-mercaptopurine (Purinethol) or methotrexate?

Yes

No

Q9. Has the patient failed, had an inadequate response or is there any contraindication for patient to try Humira OR has the patient been currently established on therapy with Cimzia (within the last 90 days)?

Yes

No

Q10. Is the patient 18 years of age and has a diagnosis of active ankylosing spondylitis?

Yes

No

Q11. Is the prescriber a rheumatologist or in consultation with a rheumatologist?

Yes

No

Q12. Has the patient failed, had an inadequate response to a trial of at least one or more DMARD or have contraindications or intolerances to DMARDs [e.g., NSAIDs, Azulfidine (sulfasalazine), methotrexate]?

Yes

No

Q13. Has the patient failed, had an inadequate response, or is there any contraindication for patient to try Enbrel and Humira OR has the patient been currently established on therapy with Cimzia (within the last 90 days)?

Yes

No

Q14. Is the patient 18 years of age and has a diagnosis of Psoriatic Arthritis?

Yes

No

Q15. Is the prescriber a dermatologist or a rheumatologist or in consultation with a dermatologist or rheumatologist?

Yes

No

Q16. Has the patient failed or had an inadequate response to a trial of at least one or more DMARD or have contraindications or intolerances to DMARDs [e.g., NSAIDs, corticosteroids, Azulfidine (sulfasalazine), Plaquenil, Imuran, leflunomide, cyclosporine, methotrexate]?

Yes

No

Q17. Has the patient failed, had an inadequate response, or is there any contraindication for patient to try Enbrel and Humira OR has the patient been currently established on therapy with Cimzia (within the last 90 days)?

Yes

No



Health Partners Plans

**HEALTH PARTNERS PLANS  
PRIOR AUTHORIZATION REQUEST FORM**

Cimzia® (certolizumab pegol)

Phone: 215-991-4300

Fax back to: 866-240-3712

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

Patient Name:

Prescriber Name:

Q18. Is the patient 18 years of age and has a diagnosis of moderate to severe plaque psoriasis and is the patient a candidate for systemic therapy or phototherapy?

Yes

No

Q19. Is the medication prescribed in consultation with a dermatologist?

Yes; patient has psoriasis with greater than 10% of the body involvement.       Yes; patient has psoriasis with less than 10% of the body involvement.

Q20. For psoriasis (greater than 10% of the body involvement): Has the patient failed or had an inadequate response to the trial of Methotrexate OR UVB therapy (alone or in combination with other medications) OR Soriatane (requires prior authorization)?

Yes

No

Q21. For psoriasis (less than 10% of the body surface area involvement): Has the patient failed, had an inadequate response or unable to tolerate the following trial of Tar, 1 topical steroid (high to very high potency for body areas) AND Dovonex (for body), tacrolimus (for face and other sensitive areas) or Anthralin?

Yes

No

Q22. Has the patient failed, had an inadequate response, or is there any contraindication for patient to try Enbrel and Humira OR has the patient been currently established on therapy with Cimzia (within the last 90 days)?

Yes

No

Q23. Has patient been evaluated for active or latent tuberculosis infection with a tuberculin skin test prior to the initiation of therapy?

Yes

No

Q24. Is the tuberculin skin test negative?

Yes

No

Q25. If latent infection is diagnosed, has the patient received appropriate prophylaxis in accordance with the CDC and prevention guidelines should be instituted?

Yes

No

Q26. Is the patient being treated for any other active infection?

Yes

No

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

Updated 2018