Premier Health Plan
Pharmacy Services
Commercial Phone: 855-266-0713
Exchange Phone: 866-822-2413
Fax: 855-862-6518

CIMZIA
Prior Authorization Form

□ Standard Request □ Expedited Request	If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. ***For state exchanges only:*** The above disclaimer applies for exigent circumstances. Expedited review may also be requested when you are undergoing a current course of treatment using a non-formulary drug.

Demographics

Patient Information			Prescriber Information		
Patient Name:			Prescriber Name:		
DOB:	Age:		NPI#:	Specialty:	
Health Plan ID#:			Phone:	Fax:	
Pharmacy Name:	Pharmacy Phone:		Office Contact:	Direct Phone # or Ext:	

Medication Information

Medication:	Strength:	Directions:	Quantity Dispensed:	Day Supply:
Cimzia				
□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.		

Billing Information

□ Billed by **PHARMACY** dispensed to the member *or* provider for administration.	□ Billed under **MEDICAL** benefit by provider. J CODE:_____ ICD-10 Code:_____	Place of Administration: □ Physician's Office □ Hospital/Clinic □ Patient Home

Clinical Information

Diagnosis	Is the member's disease currently active?
□ **Rheumatoid Arthritis**	□ Yes □ No
□ **Psoriatic Arthritis**	□ Yes □ No
□ **Crohn's Disease**	□ Yes □ No
□ **Ankylosing Spondylitis**	□ Yes □ No □ Dominant Axial □ Dominant Peripheral

Disease Severity:
□ Mild
□ Moderate
□ Severe

PPD (tuberculin) test:
□ Positive
□ Negative
Date:_____

Is the member currently using another TNF-blocking or biologic agent in combination with Cimzia? □ Yes □ No

*Medication:*_____

Does the member currently have evidence of infection? □ Yes □ No

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Page 2		
Member Name:	DOB:	Health Plan ID:
Please be sure to complete and include this page with the 1st page of this form.		

Please indicate past medication(s) tried and failed:
****Cimzia, when self-administered, requires prior drug therapy with ***both*** preferred TNF products.****

Medication	Start Date	End Date	Strength	Frequency	Reason for Discontinuing
☐ Methotrexate					
☐ Hydroxychloroquine					
☐ Leflunomide					
☐ Minocycline					
☐ Sulfasalazine					
☐ Azathioprine					
☐ 6-Mercaptopurine					
☐ Cyclosporine					
☐ **ENBREL****					
☐ **HUMIRA****					
☐ Remicade					
☐ Simponi					
☐ NSAID's (provide names):					
☐ Corticosteroids (provide names):					
☐ Other (provide names):					

Please provide any additional information which should be considered in the space below:

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