Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

{{PANUMCODE}}

{{DISPLAY_PAGNAME}}
{{PACDESCRIPTION}}

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to {{COMPANY_NAME}} at {{CLIENT_PAG_FAX}}. Please contact {{COMPANY_NAME}} at {{CLIENT_PAG_PHONE}} with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of {{DRUGNAME}}.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}} **Patient Phone:** <<MEMPHONE>>
Specialty: _____ **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Physician Office Address: <<PHYADDRESS1>> <<PHYADDRESS2>> <<PHYCITY>>, <<PHYSTATE>> <<PHYZIP>>
Drug Name: {{DRUGNAME}}

Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: <<DIAGNOSIS>> **ICD Code**: <<ICD9>>

1. What is the prescribed dose and frequency?
   a) **Loading dose:**
   - ❑ Cimzia Starter Kit — Quantity and Frequency: _____
   - ❑ Cimzia 200 mg PFS (prefilled syringe) — Quantity and Frequency: _____
   - ❑ Cimzia Kit (lyophilized powder - vial) — Quantity and Frequency: _____
   - ❑ Other _____

   b) **Maintenance dose:**
   - ❑ Cimzia 200 mg PFS (prefilled syringe) — Quantity and Frequency: _____
   - ❑ Cimzia Kit (lyophilized powder - vial) — Quantity and Frequency: _____
   - ❑ Other _____

2. Has the patient been diagnosed with any of the following?
   - ❑ Moderately to severely active rheumatoid arthritis (RA)
   - ❑ Active psoriatic arthritis (PsA)
   - ❑ Active psoriatic arthritis (PsA) WITH co-existent plaque psoriasis
   - ❑ Active ankylosing spondylitis (AS)
     Please indicate primary diagnosis being treated:
     ❑ Active psoriatic arthritis ❑ Moderate to severe plaque psoriasis
   - ❑ Active non-radiographic axial spondyloarthritis
   - ❑ Moderate to severe plaque psoriasis
   - ❑ Moderately to severely active Crohn's disease (CD)
   - ❑ Immune checkpoint inhibitor-related inflammatory arthritis
   - ❑ Other _____

3. What is the ICD-10 code? _____

4. What is the patient's weight? _____ kg/lbs ***(circle one)***

5. Is the requested drug being prescribed by or in consultation with any of the following specialists?
   ❑ Dermatologist ❑ Gastroenterologist ❑ Rheumatologist ❑ None of the above

6. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Otezla, Xeljanz) for the same indication? ❑ Yes ❑ No

7. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis? *If Yes, skip to #11* ❑ Yes ❑ No

8. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [TST], interferon-release assay [IGRA]) within 6 months of initiating therapy? ❑ Yes ❑ No

9. What were the results of the tuberculosis (TB) test?
❑ Positive for TB ❑ Negative for TB, *skip to #11* ❑ Unknown

10. Does the patient have latent or active tuberculosis (TB)?
❑ Patient has latent TB and treatment for latent TB has been initiated
❑ Patient has latent TB and treatment for latent TB has been completed
❑ Patient has latent TB and treatment for latent TB has not been initiated
❑ Patient has active TB

11. Is this request for continuation of therapy with the requested drug?
❑ Yes ❑ No *If No, skip to diagnosis section.*

12. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to diagnosis section and complete all applicable questions related to an initial request.* ❑ Yes ❑ No ❑ Unknown

13. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?
❑ Yes ❑ No

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

Section A: Rheumatoid Arthritis

Continuation

1. Has the patient experienced substantial disease activity improvement (e.g., at least 20% from baseline) in tender joint count, swollen joint count, pain, or disability? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting positive clinical response and substantial disease activity improvement.*** ❑ Yes ❑ No

Initiation

2. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) indicated for treatment of moderately to severely active rheumatoid arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)?
ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions. ❑ Yes ❑ No

3. Does the patient meet either of the following: a) the patient was tested for the rheumatoid factor (RF) biomarker and the RF biomarker test was positive, or b) the patient was tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker and the anti-CCP biomarker test was positive? ***ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing and skip to #6.*** ❑ Yes ❑ No

4. Has the patient been tested for all of the following biomarkers: a) rheumatoid factor (RF), b) anti-cyclic citrullinated peptide (anti-CCP), and c) C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR)? ***ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing.*** ❑ Yes ❑ No

5. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate at a dose greater than or equal to 15 mg per week? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and no further questions.*** ❑ Yes ❑ No

6. Has the patient experienced an intolerance to methotrexate? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and no further questions.*** ❑ Yes ❑ No

7. Does the patient have a contraindication to methotrexate? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

8. Please indicate the contraindication to methotrexate.
   - ❑ Drug interaction
   - ❑ Pregnancy or currently planning pregnancy
   - ❑ Hypersensitivity
   - ❑ Risk of treatment-related toxicity
   - ❑ Breastfeeding
   - ❑ History of intolerance or adverse event
   - ❑ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease
   - ❑ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension)
   - ❑ Other: _____

Section B: Psoriatic Arthritis

Continuation

1. Which of the following has the patient experienced an improvement in from baseline?
   ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response.
   - ❑ Number of swollen joints
   - ❑ Dactylitis
   - ❑ Number of tender joints
   - ❑ Skin and/or nail involvement
   - ❑ Enthesitis
   - ❑ Axial disease
   - ❑ Functional status
   - ❑ C-reactive protein (CRP)
   - ❑ None of the above

Initiation

2. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Otezla) indicated for active psoriatic arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.*** ❑ Yes ❑ No

3. What is the patient's disease severity? ❑ Mild to moderate ❑ Severe *If Severe, no further questions.*

4. Does the patient have enthesitis or predominantly axial disease? *If Yes, no further questions*. ❑ Yes ❑ No

5. Has the patient had an inadequate response to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine) administered at an adequate dose and duration? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and no further questions.*** ❑ Yes ❑ No

6. Has the patient had an intolerance to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and no further questions.*** ❑ Yes ❑ No

7. Does the patient have a contraindication to methotrexate or leflunomide? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No *If No, skip to #9*

8. Please indicate the contraindication to methotrexate or leflunomide. *Indicate below and no further questions.*
   - ❑ Drug interaction
   - ❑ Pregnancy or currently planning pregnancy
   - ❑ Hypersensitivity
   - ❑ Risk of treatment-related toxicity
   - ❑ Breastfeeding
   - ❑ History of intolerance or adverse event
   - ❑ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease
   - ❑ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension)
   - ❑ Other: _____

9. Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasalazine)?
   ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.
   ❑ Yes ❑ No

Section C: Ankylosing Spondylitis or Axial Spondyloarthritis

Continuation

1. Which of the following has the patient experienced an improvement in from baseline?
   ACTION REQUIRED: Please attach chart notes or medical records supporting positive clinical response.
   - ❑ Functional status
   - ❑ Total spinal pain
   - ❑ Inflammation (e.g., morning stiffness)
   - ❑ None of the above
   - ❑ Swollen joints
   - ❑ Tender joints
   - ❑ C-reactive protein (CRP)

Initiation

2. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) that is indicated for treatment of active ankylosing spondylitis or active non-radiographic axial spondyloarthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.***
   ❑ Yes ❑ No

3. Has the patient experienced an inadequate response with at least TWO non-steroidal anti-inflammatory drugs (NSAIDs), or has an intolerance or contraindication to at least two NSAIDs? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

Section D: Crohn's Disease

Continuation

1. Has the patient achieved or maintained remission? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of remission and no further questions.*** ❑ Yes ❑ No

2. Which of the following has the patient experienced an improvement in from baseline?
   ACTION REQUIRED: Please attach chart notes or medical records supporting positive clinical response.
   ❑ Abdominal pain or tenderness
   ❑ Body weight
   ❑ Hematocrit
   ❑ Diarrhea
   ❑ Abdominal mass
   ❑ Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound
   ❑ Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index [CDAI] score)
   ❑ None of the above

Section E: Plaque Psoriasis

Continuation

1. Has the patient experienced a reduction in body surface area (BSA) affected from baseline?
   ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of decreased body surface area affected and no further questions. ❑ Yes ❑ No

2. Has the patient experienced an improvement in signs and symptoms of the condition from baseline (e.g., itching, redness, flaking, scaling, burning, cracking, pain)? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of improvement in signs and symptoms.*** ❑ Yes ❑ No

Initiation

3. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Sotyktu, Otezla) indicated for the treatment of moderate to severe plaque psoriasis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED: If Yes, attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.*** ❑ Yes ❑ No

4. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected?
   ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of affected areas and no further questions. ❑ Yes ❑ No

5. Is the percentage of body surface area (BSA) affected (prior to starting the requested medication) less than 3%? ❑ Yes ❑ No

6. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)? Indicate percentage. ***ACTION REQUIRED: Please attach chart notes or medical record documentation of body surface area affected.*** _____ % *If greater than or equal to 10% of BSA, no further questions.*

7. Has the patient experienced an inadequate response, or has an intolerance to phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and no further questions.*** ❑ Yes ❑ No

8. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

9. Please indicate the contraindication to methotrexate or leflunomide.
   ❑ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease
   ❑ Drug interaction
   ❑ Risk of treatment-related toxicity
   ❑ Pregnancy or currently planning pregnancy
   ❑ Breastfeeding
   ❑ Cannot be used due to risk of treatment-related toxicity
   ❑ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension)
   ❑ Hypersensitivity
   ❑ History of intolerance or adverse event
   ❑ Other: _____

Section H: Severe Immune Checkpoint Inhibitor-Related Inflammatory Arthritis

1. Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)? ❑ Yes ❑ No

Initiation

2. Has the patient had an inadequate response to corticosteroids? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy and no further questions.*** ❑ Yes ❑ No

3. Has the patient had an inadequate response to a conventional synthetic drug (e.g., methotrexate, sulfasalazine, leflunomide, hydroxychloroquine)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy and no further questions.*** ❑ Yes ❑ No

4. Does the patient have an intolerance or contraindication to corticosteroids? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is if not advisable, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No *If No, no further questions.*

5. Does the patient have an intolerance or contraindication to a conventional synthetic drug (e.g., methotrexate, sulfasalazine, leflunomide, hydroxychloroquine)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is if not advisable, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date