together with CCHP™

# CIMZIA VIALS/SYRINGES

## Prior Authorization Form

**If this is an urgent request, please call Together with CCHP Pharmacy Services. Otherwise please return completed form to Together with CCHP Pharmacy Services.**

**Phone: 844-201-4677 or Fax: 844-201-4675**

**PLEASE TYPE OR PRINT NEATLY**

***Incomplete responses may delay this request.***

| | | | |
|---|---|---|---|
| **Office contact:** | | **Provider specialty:** | |
| **Provider first name:** | | **Provider last name:** | |
| **Provider phone #:** | **Provider fax #:** | **Provider NPI #:** | |
| **Patient name:** | **Patient UPMC Health Plan Member ID #:** | **Patient DOB:** | **Patient age:** |

| | | | |
|---|---|---|---|
| **Drug requested:** ☐ **Cimzia vials** ☐ **Cimzia syringes** | **Strength:** | **Frequency:** | **Quantity dispensed (including units):** |

***Generic equivalent drugs will be substituted for brand name drugs unless you specifically indicate otherwise.***

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|---|---|---|---|
| ☐ **New medication** ☐ **Ongoing medication** | **If ongoing, please provide start date:** | **If ongoing, did the member show improvement while on therapy?** | ☐ **Yes** ☐ **No** |
| **Diagnosis:** | | **Date of diagnosis:** | |

**Place of administration:** ☐ Physician's Office ☐ Hospital/Facility ☐ Patient Home ☐ Other

**Please provide hospital/facility information:**
**Name:**_____
**Phone:** _____
**Address:**_____
_____

**Please indicate how medication will be billed:**
☐ Billed directly by the provider via JCODE
JCODE: _____
☐ Billed by a pharmacy and delivered to the provider
☐ Billed by a pharmacy and delivered to the patient

**Please complete all of the following sections:**

Please indicate disease severity: ☐ Mild ☐ Moderate ☐ Severe

Is the member's disease currently active? ☐ Yes ☐ No

Date of most recent tuberculosis skin test:_____ Result of tuberculosis skin test: ☐ Positive ☐ Negative

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

Is the member currently using another TNF-blocking or biologic agent in combination with Cimzia? ☐ Yes ☐ No
If yes, please provide name of medication: _____

**Please indicate the *diagnosis* on the left and complete the corresponding questions.**

☐ Rheumatoid Arthritis

☐ Crohn's Disease

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| ☐ Psoriatic Arthritis | Please indicate the type of disease:<br>☐ Peripheral ☐ Dactylitis ☐ Axial ☐ Enthesitis ☐ Skin and Nail Disease |
| | For Peripheral, Dactylitis, Axial, or Enthesitis disease:<br>Has the member tried and failed any NSAIDs for at least 4 weeks? ☐ Yes ☐ No<br>If yes, please provide drug name(s) and reason for discontinuation on page 2. |
| | For Skin and Nail disease:<br>Has the member tried and failed topical treatments, phototherapy, photochemotherapy? ☐ Yes ☐ No |
| ☐ Plaque Psoriasis | Please indicate % body surface area involvement: ☐ Less than 5% ☐ Greater than or equal to 5% |
| | Does the member have plaque psoriasis on the palms, soles, head, neck or genitalia? ☐ Yes ☐ No |
| | Has the member tried and failed topical treatments, phototherapy, photochemotherapy? ☐ Yes ☐ No |
| ☐ Ankylosing Spondylitis | Has the member tried and failed any NSAIDs for at least 4 weeks? ☐ Yes ☐ No<br>If yes, please provide drug name(s) and reason for discontinuation on page 2. |

**Please be sure to complete and include the 2nd page of this form.**

# CIMZIA—PAGE 2

| Patient Name | Patient UPMC Health Plan ID Number: | Patient DOB: |
|---|---|---|
| | | |

**Please be sure to complete and include the 1st page of this form.**

## PREVIOUS MEDICATION HISTORY

**Please list all previous medication(s) tried and failed, including but not limited to NSAIDs, topical therapies, corticosteroids, conventional systemic therapies, and biologic therapies.**

| Medication name | Start date | End date | Strength | Frequency | Reason for failure, discontinuation |
|---|---|---|---|---|---|
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**Please provide any additional information in the space below.**