



Send completed form to:  
 Peach State Health Plan Pharmacy Department  
 Fax: 1-866-374-1579

## Cimzia

### Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copy or medication delivery; please contact Peach State Health Plan at 1-800-514-0083 option # 2.

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Patient's ID:** \_\_\_\_\_ **Patient's Date of Birth:** \_\_\_\_\_  
**Physician's Name:** \_\_\_\_\_  
**Specialty:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Physician Office Telephone:** \_\_\_\_\_ **Physician Office Fax:** \_\_\_\_\_  
**Physician Office Address:** \_\_\_\_\_

1. Which drug is being prescribed?  Cimzia, Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_  
 Other \_\_\_\_\_
2. What is the diagnosis?  Rheumatoid Arthritis  Crohn's disease  Other \_\_\_\_\_
3. How old is the patient? \_\_\_\_\_ years
4. What is the medical specialty of the prescribing physician?  Rheumatologist  Dermatologist  
 Colorectal Specialist  Gastroenterologist  Other \_\_\_\_\_
5. Does the patient have negative tuberculosis (TB) test? *\*If yes, skip to # 8*  Yes  No
6. Has active TB been ruled out via negative chest x-ray?  Yes  No
7. Was chest x-ray taken within last 12 months?  Yes  No
8. Does the patient have signs or symptoms of active infection, either chronic or localized?  
 Yes  No
9. Does the patient have a history of hepatitis B infection?  Yes  No
10. Has the patient been treated for hepatitis B infection?  Yes  No
11. Does the patient have a history of any of the following diseases?  Yes  No  
 Congestive cardiac failure (New York Heart Association grade III or IV)  
 Multiple sclerosis or other demyelinating disease  
 Malignant disease
12. Will Cimzia be used in combination with any other biologic medications?  Yes  No
13. Is the patient currently receiving Cimzia therapy?  Yes  No *\*If no, skip to # 16*
14. Did the patient demonstrate a therapeutic response?  Yes  No
15. Does the prescribed dose exceed 400mg per month?  Yes  No

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Patient Name: \_\_\_\_\_ Patients Date of Birth: \_\_\_\_\_  
Patients ID : \_\_\_\_\_

16. Has the patient had a trial of biologic therapy other than Cimzia for 3 consecutive months?  
 Yes  No *\*If no, skip to diagnosis section*  
 Enbrel  Humira  Kineret  Oencia  Remicade  Rituxan  Simponi
17. Has the patient had an inadequate response to previous biologic therapy?  Yes  No
18. Was the patient adherent to prescribed biologic therapy?  Yes, **submit documentation**  No
19. Was the patient intolerant to previous biologic therapy?  Yes, **submit documentation**  No

*Complete the Section below designated for the patient's diagnosis*

**Section A: Rheumatoid Arthritis**

20. Prior to therapy, did the patient have 6 or more inflamed joints?  Yes  No
21. Prior to therapy, did the patient have at least one of the following characteristics?  Yes  No  
 Elevation of erythrocyte sedimentation rate and/or serum c-reactive protein concentration  
 Positive rheumatoid factor and/or anti-cyclic citrullinated peptide  
 Radiography showing evidence of rheumatoid arthritis, including osteopenia and/or joint space narrowing and/or bony erosions and/or loss of cartilage
22. Has the patient had a trial of either methotrexate or leflunomide for at least 3 consecutive months?  
 Yes  No *\*If no, skip to # 24*
23. Has the patient had an inadequate response to either methotrexate or leflunomide? *\*If yes, skip to # 28*  
 Yes  No
24. Is the patient intolerant or contraindicated to either methotrexate or leflunomide?  Yes  No
25. Has the patient had a trial of another nonbiologic DMARD for at least 3 consecutive months (e.g., hydroxychloroquine, cyclosporine, sulfasalazine, gold, azathioprine)?  Yes  No
26. Has the patient had an inadequate response to such therapy?  Yes  No
27. Is the patient intolerant or contraindicated to such therapy?  Yes  No
28. Was the patient adherent to prescribed therapy?  Yes  No
29. **Submit documentation of last trial of nonbiologic DMARD.**

**Section B: Crohn's Disease**

30. Has the diagnosis been made by a gastrointestinal or colorectal specialist?  Yes  No
31. Does the patient have fistulizing Crohn's?  Yes, **submit documentation**  No
32. Select all of the following drugs the patient is **intolerant** or **contraindicated** to:  
 Azathioprine  Mercaptopurine  Corticosteroids  
 Methotrexate  Aminosalicylates  Other \_\_\_\_\_
33. Select all of the following drugs the patient has **tried** and had an **inadequate response** to:  
 Azathioprine  Mercaptopurine  Corticosteroids  
 Methotrexate  Aminosalicylates  Other \_\_\_\_\_
34. Has the patient been on such therapy for at least 3 consecutive months?  Yes  No

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Patients ID : \_\_\_\_\_

35. Does the patient have documentation of rapidly progressive disease-related symptoms while on conventional oral therapy?  Yes, **submit documentation**  No
36. Was the patient adherent to prescribed therapy?  Yes  No
37. Was the patient intolerant to prescribed conventional oral therapy?  Yes  No
38. **Submit documentation** of last trial of conventional therapy unless contraindicated.

**\*\*NOTE: We can NOT make a decision without a copy of the documentation - Thank You\*\***

*Information given on this form is accurate as of this date:*

**X** \_\_\_\_\_  
Prescriber or Authorized Signature Date (mm/dd/yy)

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