Cimzia® (certolizumab)

Medication Request Form (MRF) for Healthy Indiana Plan (HIP) and Hoosier Healthwise (HHW)
FAX TO: (858) 790-7100
c/o MedImpact Healthcare Systems, Inc.
Attn: Prior Authorization Department
10181 Scripps Gateway Court, San Diego, CA 92131 - Phone: 1-800-788-2949

Instructions:
This form is to be used by participating providers to obtain coverage for the drug listed above which requires *prior authorization*. Please complete this form and fax it to *Med**Impact*** Healthcare Systems, Inc. at (858) 790-7100. If you have any questions regarding this process, please contact Med***Impact***'s Customer Service at (800) 788-2949.

Member/Provider Information:

MDwise Member's Name:	**Provider's Name:**
MDwise Member's ID #:	**Provider's Specialty:**
MDwise Member's DOB (mm-dd-yy):	**Provider's DEA #:** | **Provider's NPI #:**
Pharmacy used by MDwise Member:	**Provider's Telephone Number/Contact Name (xxx-xxx-xxxx):**
Pharmacy Telephone Number (xxx-xxx-xxxx):	**Provider's Fax Number (xxx-xxx-xxxx):**

Clinical Information:

Requested Drug: ☐ **Cimzia®**	
Dose and Quantity Requested:	
Date Requested:	**Length of Treatment** (please be specific)**:**

Documentation of Medical Necessity (please complete **ONE** of the following four sections and if desired section 5**):**

1. Does the patient have a diagnosis of moderate to severe Crohn's disease? ☐ Yes ☐ No

AND

Is this for initial therapy (i.e., is the patient naïve to this medication)? ☐ Yes ☐ No

If no, has the patient experienced or maintained symptomatic improvement while on therapy? ☐ Yes ☐ No

AND

Has this treatment been prescribed by or in consultation with a gastroenterologist? ☐ Yes ☐ No

AND

Has the patient tried or does the patient have a contraindication (CI) to at least **ONE** of the following conventional agents?

mesalamine	☐ Yes	☐ No	If **yes**, describe response/reaction or CI to each medication below:
azathioprine	☐ Yes	☐ No	_____
methotrexate	☐ Yes	☐ No	_____
mercaptopurine	☐ Yes	☐ No	_____
corticosteroids	☐ Yes	☐ No	

2. Does the patient have a diagnosis of **moderate to severe rheumatoid arthritis**? ☐ Yes ☐ No

AND

Is this for initial therapy (i.e., is the patient naïve to this medication)? ☐ Yes ☐ No

If no, has the patient experienced or maintained ≥20% improvement in tender or swollen joint count while on therapy? ☐ Yes ☐ No

AND

Has this treatment been prescribed by or in consultation with a rheumatologist? ☐ Yes ☐ No

AND

Has the patient tried or does the patient have a contraindication to at least **ONE** of the following DMARD agents?

methotrexate	☐ Yes	☐ No	**If yes**, describe the response/reaction or CI to each medication below:
leflunomide	☐ Yes	☐ No	_____
hydroxychloroquine	☐ Yes	☐ No	_____
sulfasalazine	☐ Yes	☐ No	_____

3. Does the patient have a diagnosis of **active psoriatic arthritis**? ☐ Yes ☐ No

AND

Is this for initial therapy (i.e., is the patient naïve to this medication)? ☐ Yes ☐ No

If no, has the patient experienced or maintained ≥20% improvement in tender or swollen joint count while on therapy? ☐ Yes ☐ No

AND

Has this treatment been prescribed by or in consultation with a rheumatologist or a dermatologist? ☐ Yes ☐ No

AND

Has the patient tried or does the patient have a contraindication to at least **ONE** of the following DMARD agents?

methotrexate	☐ Yes	☐ No	**If yes**, describe the response/reaction or CI to each medication below:
leflunomide	☐ Yes	☐ No	_____
hydroxychloroquine	☐ Yes	☐ No	_____
sulfasalazine	☐ Yes	☐ No	_____

4. Does the patient have a diagnosis of **moderate to severe plaque psoriasis**? ☐ Yes ☐ No

AND

Is this for initial therapy (i.e., is patient naïve to this medication)? ☐ Yes ☐ No

If no, did the patient achieve or maintain clear or minimal disease or experience a decrease in PASI (Psoriasis Area and Severity Index) of at least 50% or more while on therapy? ☐ Yes ☐ No

AND

Has this treatment been prescribed by or in consultation with a dermatologist? ☐ Yes ☐ No

AND

Does the plaque psoriasis involve at least 10% body surface area (BSA) or do the psoriatic lesions affect the face, hands, feet, or genital area? ☐ Yes ☐ No

AND

Has the patient tried or have a contraindication to at least **ONE** of the following preferred therapies?

PUVA (Phototherapy Ultraviolet Light A) ☐ Yes ☐ No

UVB (Ultraviolet Light B) ☐ Yes ☐ No

methotrexate ☐ Yes ☐ No

topical corticosteroids ☐ Yes ☐ No

acitretin ☐ Yes ☐ No

calcipotriene ☐ Yes ☐ No

If yes, describe the response/reaction or CI to each treatment below:

_____

_____

5.	Does the patient have a diagnosis of **ankylosing spondylitis**?	☐ Yes	☐ No
	AND		
	Is this for initial therapy (i.e., Is the patient naïve to this medication)?	☐ Yes	☐ No
	If no, has the patient experienced or maintained an improvement ≥50% or 2 units on the Bath Ankylosing Spondylitis Disease Activity Index (BASDAI)?	☐ Yes	☐ No
	AND		
	Has this treatment been prescribed by or in consultation with a rheumatologist?	☐ Yes	☐ No
6.	Please attach additional information which may indicate ***why this specific medication*** is being requested for this patient.		