

CIMZIA**Prior Authorization Form**

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES

PHONE 800-979-UPMC (8762)

FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY*Please complete all sections of this form. 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 ID Number:	Patient DOB:	Patient Age:
Drug Requested:	Strength:	Frequency:	Qty Dispensed:

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

<input type="checkbox"/> New medication	If ongoing, provide date started:	If medication is ongoing, Did member show improvement while on therapy?	<input type="checkbox"/> Yes
<input type="checkbox"/> Ongoing medication			<input type="checkbox"/> No

Diagnosis:	Date of diagnosis:
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Please indicate place of administration:	<input type="checkbox"/> Physician's Office	Will the drug be: (select one)
	<input type="checkbox"/> Hospital/Clinic	
Please provide hospital/facility name and address:		<input type="checkbox"/> Billed directly by the provider via JCODE JCODE: _____
		<input type="checkbox"/> Billed by a pharmacy and delivered to the provider
		<input type="checkbox"/> Billed by a pharmacy and delivered to the patient

Please complete the following questions for all diagnoses.

Please indicate disease severity:	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Is there evidence of Infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Date of PPD (tuberculin) test:	Result of PPD test:	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative
Is the member currently using another TNF-blocking agent or biologic agent in combination with Cimzia?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please indicate drug name:			

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

<input type="checkbox"/> Rheumatoid Arthritis	Has the member tried and failed Methotrexate for at least 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Please provide dates of therapy and dose: Reason for discontinuation:
	Please indicate if the member tried and failed any of the following for at least 3 months?
	<input type="checkbox"/> Leflunomide (Arava) <input type="checkbox"/> Minocycline <input type="checkbox"/> Sulfasalazine (Azulfidine) <input type="checkbox"/> Hydroxychloroquine (Plaquenil)
	Please provide dates of therapy and dose: Reason for discontinuation:
<input type="checkbox"/> Crohn's Disease	Has the member tried and failed Corticosteroids? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Please provide dates of therapy and dose: Reason for discontinuation:
	Please indicate if the member tried and failed any of the following for at least 3 months?
	<input type="checkbox"/> Azathioprine (Imuran) <input type="checkbox"/> 6-mercaptopurine (Purinethol) <input type="checkbox"/> Other, Please list drug name:
	Please provide dates of therapy and dose: Reason for discontinuation:

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

