# UPMC Health Plan

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

| | |
|---|---|
| **Office contact:** | **Provider specialty:** |
| **Provider first name:** | **Provider last name:** |
| **Provider phone #:** | **Provider fax #:** |

| **Patient name:** | **Patient UPMC Health Plan Member ID #:** | **Patient DOB:** | **Patient age:** |
|---|---|---|---|

| **Drug requested:**<br>☐ Brand ☐ Generic | **Strength:** | **Frequency:** | **Quantity dispensed (including units):** |
|---|---|---|---|

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

| ☐ **New medication**<br>☐ **Ongoing medication** | **If ongoing, please provide start date:** | **If ongoing, did the member show improvement while on therapy?** | ☐ **Yes**<br>☐ **No** |
|---|---|---|---|

| | |
|---|---|
| **Diagnosis:** | **Date of diagnosis:** |
| **Please indicate place of administration**<br>☐ Physician office<br>☐ Hospital/Clinic<br>☐ Patient home<br>**Please provide hospital/facility name and address:** | **Will the medication be (select one):**<br>☐ Billed directly by the provider via JCODE<br>JCODE: ____________________<br>☐ Billed by a pharmacy and delivered to the provider<br>☐ Billed by a pharmacy and delivered to the patient |

**Please complete the following for all diagnoses:**

Please indicate disease severity ☐ Mild ☐ Moderate ☐ Severe

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 past medication(s) tried and failed:**
**(Cimzia, when self-administered, requires prior drug therapy with both preferred TNF products.)**

| Medication name | Start date | End date | Strength | Frequency | Reason for failure, discontinuation |
|---|---|---|---|---|---|
| ☐ Methotrexate | | | | | |
| ☐ Hydroxychloroquine | | | | | |
| ☐ Leflunomide | | | | | |
| ☐ Minocycline | | | | | |
| ☐ Sulfasalazine | | | | | |
| ☐ Azathioprine | | | | | |
| ☐ 6-Mercaptopurine | | | | | |
| ☐ Cyclosporine | | | | | |
| ☐ **ENBREL**** | | | | | |
| ☐ **HUMIRA**** | | | | | |
| ☐ Remicade | | | | | |
| ☐ Simponi | | | | | |

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

****ENBREL AND HUMIRA ARE THE PREFERRED TNF PRODUCTS FOR UPMC HEALTH PLAN**

# 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.**

**Please indicate past medication(s) tried and failed:**

| Medication name | Start date | End date | Strength | Frequency | Reason for failure, discontinuation |
|---|---|---|---|---|---|
| ☐ Non-Steroidal Anti-Inflammatory Drugs (please provide names): | | | | | |
| | | | | | |
| | | | | | |
| ☐ Corticosteroids (please provide names): | | | | | |
| | | | | | |
| | | | | | |
| ☐ Other (please provide names): | | | | | |
| | | | | | |
| | | | | | |

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

| Diagnosis | Question | Response |
|---|---|---|
| ☐ **Rheumatoid Arthritis**<br>☐ **Psoriatic Arthritis**<br>☐ **Crohn's Disease** | Is the member's disease currently active? | ☐ Yes ☐ No |
| ☐ **Ankylosing Spondylitis** | Is the member's disease currently active? | ☐ Yes ☐ No |
| | Is the member's disease dominant axial? | ☐ Yes ☐ No |
| | Is the member's disease dominant peripheral? | ☐ Yes ☐ No |

**Please provide any additional information in the space below.**