

Immunomodulators: Cimzia

Member Information

1. Member Last Name: _____ 2. First Name: _____
3. Member ID #: _____ 4. Member Date of Birth: _____ 5. Member Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): up to 30 Days 60 Days 90 Days 120 Days 180 Days 365 Days
Other _____

Clinical Information

Request for Ankylosing Spondylitis

1. Does the member have a diagnosis of Ankylosing Spondylitis? Yes No
2. Is the member not on another injectable biologic immunomodulator? Yes No
3. Has the member been considered and screened for the presence of latent tuberculosis infection? Yes No
4. Has the member been tested with Hep B SAG and Core Ab? Yes No
5. Has the member experienced inadequate symptom relief from treatment with at least two NSAIDS? Yes No
6. Is the member unable to receive treatment with NSAIDS due to contraindications? Yes No
7. Does the member have clinical evidence of severe or rapidly progressing disease
8. Has the member had a trial and failure of Cosentyx, Enbrel or Humira or a clinical reason member cannot try Cosentyx, Enbrel or Humira? Yes No

Request for Crohn's Disease (Adult)

1. Does the member have a diagnosis of moderate to severe Crohn's Disease? Yes No
2. Is the member not on another injectable biologic immunomodulator? Yes No
3. Has the member been considered and screened for the presence of latent tuberculosis infection? Yes No
4. Has the member been tested with Hep B SAG and Core Ab? Yes No
5. Has the member had a trial and failure of Humira or a clinical reason member cannot try Humira? Yes No

Request for Plaque Psoriasis (Adult)

1. Does the member have a documented definitive diagnosis of moderate-to-severe Chronic Plaque Psoriasis? Yes No
2. Is the member 18 years of age or older? Yes No
3. Is the member not on another injectable biologic immunomodulator? Yes No
4. Has the member been considered and screened for the presence of latent tuberculosis infection (not required for Otezla)? Yes No
5. Has the member been tested with Hep B SAG and Core Ab? Yes No
6. Does the member have a body surface area (BSA) involvement of at least 3%? Yes No

7. Does the member have involvement of the palms, soles, head and neck, or genitalia, causing disruption in normal daily activities and/or employment? Yes No
8. Has the member failed to respond to, or has been unable to tolerate phototherapy and **ONE** of the following medications or member has contraindications to these treatments: Soriatane (acitretin), Methotrexate, and/or Cyclosporine? Yes No
9. Has the member had a trial and failure of Cosentyx, Enbrel or Humira or a clinical reason member cannot try Cosentyx, Enbrel or Humira? Yes No
10. Are the beneficiaries, Providers, and Pharmacies utilizing Siliq registered appropriately in the Siliq Risk Evaluation and Mitigation Strategy Program (REMS program)? Yes No

Request for Psoriatic Arthritis

1. Does the member have a documented definitive diagnosis of Psoriatic Arthritis? Yes No
2. Is the member 18 years of age or older (OR 2 years or older for Simponi Aria)? Yes No
3. Is the member not on another injectable biologic immunomodulator? Yes No
4. Has the member been considered and screened for the presence of latent tuberculosis infection (not required for Otezla)? Yes No
5. Has the member been tested with Hep B SAG and Core Ab (not required for Otezla)? Yes No
6. Does the member have a documented inadequate response or inability to take methotrexate? Yes No
7. Has the member had a trial and failure of Cosentyx, Enbrel or Humira or a clinical reason member cannot try Cosentyx, Enbrel or Humira? Yes No

Request for Rheumatoid Arthritis

1. Does the member have a diagnosis of Rheumatoid Arthritis? Yes No
2. Is the member not on another injectable biologic immunomodulator? Yes No
3. Has the member been considered and screened for the presence of latent tuberculosis? Yes No
4. Has the member been tested with Hep B SAG and Core Ab? Yes No
5. Has the member experienced a therapeutic failure/inadequate response with methotrexate or at least one disease modifying antirheumatic drug (e.g. leflunomide, hydroxychloroquine, minocycline, sulfasalazine)? Yes No
6. Is the member unable to receive methotrexate or disease modifying antirheumatic drug due to contraindications or intolerabilities? Yes No
7. Does the member have clinical evidence of severe or rapidly progressing disease? Yes No
8. Has the member had a trial and failure of Enbrel or Humira or a clinical reason member cannot try Enbrel or Humira? Yes No

Request for Non-Radiographic Axial Spondyloarthritis

1. Does the member have a diagnosis of Non-Radiographic Axial Spondyloarthritis? Yes No
2. Is the member not on another injectable biologic immunomodulator? Yes No
3. Has the member failed an adequate trial of a Non-Steroidal Anti-Inflammatory Drug (NSAID) unless contraindicated? Yes No
4. Has the member been considered and screened for the presence of latent tuberculosis? Yes No
5. Has the member been tested with Hep B SAG and Core Ab? Yes No
6. Has the member had a trial and failure of Cosentyx? Yes No

**Trillium Health Resources
Pharmacy Prior Approval Request for**



Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.