

CIMZIA (certolizumab)

SPECIALTY PHARMACY PRIOR AUTHORIZATION REQUEST FORM

| Patient Information | |
|---------------------|-----------------|
| Name: | Member ID #: |
| Group Name: | Date of Birth: |
| Diagnosis: | Diagnosis Code: |

| Provider Information | |
|----------------------|---------------------|
| Prescriber's Name: | Prescriber's DEA #: |
| Phone: | Fax: |
| Office Address: | |

Complete and review information, sign and date. Fax signed form to Caremark Specialty's prior authorization department at 1-866-249-6155. The Caremark fax machine is located in a secure location as required by HIPAA regulations. On behalf of the member's health plan, Caremark assists in the administration of the prior authorization program. Caremark is an independent company that administers prescription drug benefits.

Providers may call Caremark at 1-866-814-5506 with any questions concerning prior authorization procedures. For questions related to the patient's eligibility, drug copay or delivery, providers and members should call Caremark Specialty Customer Care at 1-866-513-5214 with any questions. Members may also call their health plan at the number indicated on their Member ID cards.

Please check or circle the appropriate answer for each applicable question (Y for Yes, N for No).

1. What drug is being prescribed?
2. Is prescribed drug being used as a single Biologic Response Modifier (e.g. Amevive, Cimzia, Enbrel, Humira, Raptiva, Remicade)? Y N
3. What is the primary diagnosis? Adult Rheumatoid Arthritis Juvenile Rheumatoid Arthritis
 Psoriatic Arthritis Ankylosing Spondylitis Crohn's Disease Psoriasis
 Ulcerative Colitis Reactive Arthritis Pyoderma gangrenosum Wegener's granulomatosis
 Inflammatory Bowel Disease Arthritis Myelosclerosis with myeloid metaplasia Behcet's disease
 Hidradenitis suppurativa Other (specify): _____
4. Has the patient been tested for latent Tuberculosis (TB)? Y N

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| 5. Was the TB test Positive or Negative? | Positive | Negative | | |
|---|----------|----------|---|-----|
| [If the answer is negative, may skip to question 8.] | | | | |
| 6. If positive, has active Tuberculosis (TB) been ruled out? | | Y | N | |
| 7. If TB has been ruled out, has antibiotic prophylaxis for latent TB been initiated? | | Y | N | |
| 8. Is patient at risk for Hepatitis B Virus (HBV) infection? | | Y | N | |
| 9. Has Hepatitis B been ruled out or treatment initiated? | | Y | N | |
| 10. Does patient have other active infection (chronic or localized)? | | Y | N | |
| 11. Does patient have pre-existing or recent onset demyelinating disease (e.g., Multiple Sclerosis)? | | Y | N | |
| 12. Does patient have unstable moderate to severe Congestive Heart Failure (CHF)? | | Y | N | |
| 13. Is patient currently on therapy with the Biologic Response Modifier being prescribed (Cimzia, Humira, or Remicade)? | | Y | N | |
| [If the answer is yes, may skip to question 18.] | | | | |
| 14. Has patient tried and had inadequate response to conventional therapy? | | Y | N | |
| 15. Please document previous treatment regimen. | | | | |
| <input type="checkbox"/> Sulfasalazine (Azulfidine, Sulfazine) <input type="checkbox"/> Mesalamine, oral (Asacol, Pentasa) <input type="checkbox"/> Prednisone | | | | |
| <input type="checkbox"/> Metronidazole (Flagyl) <input type="checkbox"/> Azathioprine (Azasan, Imuran) <input type="checkbox"/> Mercaptopurine (Purinethol) | | | | |
| <input type="checkbox"/> Methotrexate <input type="checkbox"/> Hydrocortisone, IV (Solu-Cortef) <input type="checkbox"/> Cyclosporine, IV (Sandimmune) | | | | |
| <input type="checkbox"/> Remicade <input type="checkbox"/> Other (specify): _____ | | | | |
| 16. If patient had not tried and failed conventional therapy, is there a clinical reason to avoid conventional therapy as initial treatments and start biologic therapy at this time? | | Y | N | N/A |
| If yes, please document the reason: _____ | | | | |
| 17. What is the anticipated infusion date? _____ | | | | |
| 18. Is the patient experiencing a response to current biologic therapy? | | Y | N | |

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19. If the patient is not experiencing a response to current biologic therapy, is there a clinical reason for the lack of efficacy? Y N N/A

If yes, please document the reason: _____

Comments:

I affirm that the information given on this form is accurate as of this date.

Prescriber (or Authorized) Signature and Date::