

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
CIMZIA (certolizumab) for Rheumatoid Arthritis

Patient name: _____ Medicaid ID #: _____
Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____
Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____
Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____
Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY TO 855-828-4992 note the new fax number**

CRITERIA:

- Age requirement: 18 years and older
- Diagnosis of moderate to severe Rheumatoid Arthritis. The number of swollen joints, must be 6 or more **(WRITE SPECIFIC NUMBER IN NOTES OR LETTER)**
- The number of tender joints must be 9 or more **(WRITE SPECIFIC NUMBER IN NOTES OR LETTER)**
- History of treatment, incomplete response or intolerance to Methotrexate, or one other DMARD or second line drug (azathioprine, sulphadiazine, leflunomide, penicillamine, hydroxychloroquine, etc.)
- Negative TB skin test or history of treatment for latent TB infection.
- Absence of active bacterial or viral infection, malignancy, or immunosuppressive condition.
- Rheumatology consultation within the last 60 days.
- Cimzia may not be given with other biologic agents such as interferon, experimental medications or combination.

NOTES:

Available as a Non-Traditional Medicaid Benefit.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

An updated letter of medical necessity or progress notes showing improvement or maintenance on medication.

08/01/2011

<http://health.utah.gov/medicaid/pharmacy>