



Prescription Drug Coverage Determination Form
Tumor Necrosis Factor Inhibitor
Cimzia® (certolizumab)

Please fax the completed form to Mercy Health Plans' Pharmacy Department
at 314-214-8201 or 1-800-466-9854.

Patient Information

Patient Name: _____ Date of Birth: _____
Subscriber ID#: _____
Address _____ City _____ State _____ Zip Code _____

Physician Information

Name: _____ Specialty: _____ Tax ID#: _____
Office Address _____ City _____ State _____ Zip Code _____
Telephone: _____ Fax: _____ Contact Person _____

Physician Signature (REQUIRED): _____ Date _____

Medication Information (requests for non-formulary agents will be considered for members having a documented failure or contraindication to preferred agents.)

Medication name: _____ J-code: _____
Dose: _____ Directions: _____
Expected Duration of Therapy: _____

Prior Authorization Criteria:

- | | |
|---|--|
| 1. Is the patient 18 years of age or older? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Is the medication being requested to treat an FDA-approved indication not otherwise excluded from Part D?
Diagnosis: _____ ICD-9 code _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Does the patient have moderately to severely active Crohn's disease?
If yes:
▪ Has the patient demonstrated an inadequate response to conventional therapy for Crohn's disease (i.e., prednisone, budesonide, sulfasalazine (Azulfidine), azathioprine (Imuran), mesalamine (Asacol or Pentasa) or infliximab (Remicade))? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Was the patient evaluated for latent tuberculosis infection with a PPD tuberculin test?
If yes:
▪ Did the patient have a positive PPD tuberculin test?
▪ If yes, is the patient being treated for latent tuberculosis? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

- | | |
|--|--|
| 5. Does the patient have an active infection, including chronic and localized infections? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Is the patient receiving a biologic response modifier, either a tumor necrosis factor (TNF) blocking agent [e.g., Humira, Remicade] or an interleukin-1 receptor antagonist (IL1-Ra) [e.g., Kineret] other than Enbrel? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Has the patient been assessed for risk of active hepatitis B infection? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please provide any additional history or medical information that may support coverage (attach office notes as necessary): _____

Note: If approved coverage will be as specified in above criteria or through the end of the year (December 31, 20xx). Some medications may be subject to quantity limitations or restricted to certain pharmacies.