SENDERO HEALTH PLANS

Prior Authorization Request Form	**Cimzia**
Sendero Fax: 512-901-9724	**Phone:** 855-297-9191
URGENCY: ☐ **STANDARD**	☐ **URGENT (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health or ability to regain maximum function)**

Provider Information	**Patient Information**
Referring/Prescribing Physician: ☐ **PCP** ☐ **Specialist** **Name:** **Please identify SPECIALTY:** **DEA, NPI or TIN:** **Contact:** **Phone: ( ) Fax: ( )**	**Patient's Name:** **Birth Date:** **ID Number:** **Phone Number:** **Patient Height:** **Patient Weight:**
Indicate where the drug is being DISPENSED	**Indicate where the drug is being ADMINISTERED**
☐ **Ambulatory Surgery Center** ☐ **Home Care Agency** ☐ **Inpatient Hospital** ☐ **Long Term Care** ☐ **Outpatient Hospital** ☐ **Patient's Home** ☐ **Pharmacy** ☐ **Physician's Office** ☐ **Other (explain):**	☐ **Ambulatory Surgery Center** ☐ **Inpatient Hospital** ☐ **Long Term Care** ☐ **Outpatient Hospital** ☐ **Patient's Home** ☐ **Pharmacy** ☐ **Physician's Office** ☐ **Other (explain):** **Anticipated Date of Service:**

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

PATIENT CLINICAL INFORMATION

CRITERIA QUESTIONS:

1. Has the patient been diagnosed with any of the following?
   - ☐ Rheumatoid arthritis (RA)
   - ☐ Psoriasis
   - ☐ Ulcerative colitis (UC)
   - ☐ Crohn's Disease (CD)
   - ☐ Psoriatic arthritis (PsA)
   - ☐ Ankylosing spondylitis (AS), or Peripheral/Axial spondyloarthritis (seronegative spondyloarthropathy)
   - ☐ Juvenile idiopathic arthritis (JIA) – polyarticular, oligoarticular, or systemic
   - ☐ Hidradenitis suppurativa
   - ☐ Behcet's Disease
   - ☐ Pyoderma gangrenosum
   - ☐ Non-infectious intermediate, posterior or panuveitis
   - ☐ Other: _____
2. What is the HCPCS code? _____ What is the ICD-10 code? _____
   What is the NDC#: _____
3. Will the requested drug be used in combination with any other biologic or targeted synthetic DMARD (e.g., Olumiant, Xeljanz)? ☐ Yes ☐ No
4. Has the patient had a TB screening test (e.g., a tuberculosis skin test [PPD] or an interferon-release assay [IGRA]) within 6 months of initiating therapy? ☐ Yes ☐ No
5. What were the results of the TB screening test?
   - ☐ Positive
   - ☐ Negative
6. Does the patient have latent or active tuberculosis (TB)? ☐ Latent ☐ Active ☐ No/Neither

7. If the patient has latent or active tuberculosis, has treatment been initiated or completed?
☐ Yes - treatment initiated ☐ Yes - treatment completed ☐ No

8. Is this request for continuation of therapy? ☐ Yes ☐ No If No, skip to diagnosis section.

9. For continuation of therapy requests, has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms since starting treatment with the requested drug? ☐ Yes ☐ No

10. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? ☐ Yes ☐ No

DIAGNOSIS SECTION *Please only complete sections below that are relevant to the patient's diagnosis.*

Section A: Rheumatoid Arthritis

11. The patient has diagnosis of rheumatoid arthritis and the treatment is prescribed by or in consultation with a rheumatologist. ☐ Yes ☐ No

12. Has the patient previously received a biologic or targeted synthetic DMARD (e.g., Rinvoq, Xeljanz) that is indicated for moderately to severely active rheumatoid arthritis? ☐ Yes ☐ No If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable: _____

13. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate 25mg PO weekly* ? ☐ Yes ☐ No If the methotrexate dose is unable to be increased to 25mg PO weekly, please indicate reason: _____

14. Has the patient experienced intolerance to methotrexate? ☐ Yes ☐ No If Yes, indicate intolerance:
_____

15. Does the patient have a contraindication to methotrexate? ☐ Yes ☐ No If Yes, indicate contraindication:
_____

Section B: Crohn's Disease

16. There is documentation of moderate to severe Crohn's disease per the Crohn's Disease Activity index (CDAI):
☐ Mild = CDAI <220
☐ Moderate = CDAI 220-450
☐ Severe = CDAI >450

17. There is documentation of 1 or more of the following high-risk features:
☐ Diagnosis at age <30 years
☐ Ileal disease
☐ Penetrating or stricturing disease
☐ Perianal or severe rectal disease
☐ Extra-intestinal manifestations
☐ History of bowel resections
☐ Initial extensive bowel involvement on endoscopy
☐ None

18. The treatment is prescribed by or in consultation with a gastroenterologist ☐ Yes ☐ No

19. Has the patient previously received a biologic indicated for Crohn's disease? ☐ Yes ☐ No
If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable:
_____

20. Does the patient have perianal or fistulizing Crohn's disease? ☐ Yes ☐ No

21. Has the patient had an inadequate response to a minimum 3 month trial at the maximally indicated dose of 1 or more of the following within the last 6 months? If Yes, indicate below and no further questions.
    - ☐ Sulfasalazine
    - ☐ Mesalamine if primarily colonic disease
    - ☐ Azathioprine at minimum dose 1.5 mg/kg daily
    - ☐ 6-mercaptopurine at minimum dose 50mg daily
    - ☐ Methotrexate at minimum dose 15mg **IM or SQ** weekly
    - ☐ Systemic corticosteroids (e.g., prednisone, methylprednisolone)
    - ☐ None of the above therapies have been trialed

22. Does the patient have a contraindication or intolerance to at least 2 options listed above? ☐ Yes ☐ No If yes, please document medications and respective contraindications/intolerances:_____

Section C: Ankylosing Spondylitis, or Peripheral/Axial Spondyloarthritis (Seronegative Spondyloarthropathy)

23. The patient is diagnosed ankylosing spondylitis or peripheral/axial spondyloarthritis, and the treatment is prescribed by or in consultation with a rheumatologist. ☐ Yes ☐ No

24. Has the patient previously received a biologic indicated for active ankylosing spondylitis? ☐ Yes ☐ No
    If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable:
    _____

25. Has the patient experienced an inadequate response with at least TWO nonsteroidal anti-inflammatory drugs (NSAIDs), or has an intolerance or contraindication to at least two NSAIDs? ☐ Yes ☐ No

Psoriatic Arthritis

26. The patient is diagnosed with psoriatic arthritis and treatment is prescribed by or in consultation with a rheumatologist ☐ Yes ☐ No

27. Has the patient previously received a biologic medication, apremilast (Otezla), or targeted synthetic DMARD (e.g., Xeljanz) indicated for the treatment of psoriatic arthritis? ☐ Yes ☐ No If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable: _____

28. Has the patient experienced an inadequate response after at least 3 months of treatment with 1 or more of the following medications at the maximally tolerated dose?
    - ☐ Methotrexate – minimum dose 15mg po weekly
    - ☐ Sulfasalazine – minimum dose 2g po weekly
    - ☐ Cyclosporine
    - ☐ Leflunomide
    - ☐ Apremilast (Otezla)

29. Does the patient have a contraindication or intolerance to at least 2 options listed above? ☐ Yes ☐ No If yes, please document medications and respective contraindications/intolerances:_____

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Sendero Health Plans.

Prescriber or Authorized Signature	DATE