# Blue Cross Blue Shield/Blue Care Network of Michigan
# Medication Authorization Request Form

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

This form is to be used by participating physicians to obtain coverage for **drugs covered under the medical benefit**. For commercial members only, please complete this form and submit via fax to 1-877-325-5979. If you have any questions regarding this process, please contact BCBSM Provider Relations and Servicing or the Medical Drug Helpdesk at 1-800-437-3803 for assistance.

| PATIENT INFORMATION | | PHYSICIAN INFORMATION |
|---|---|---|
| **Name** | | **Name** |
| **ID Number** | | **Specialty** |
| **D.O.B.** | _____/_____/_____ MM/DD/YYYY<br>❑Male ❑Female | **Address** |
| **Diagnosis** | | **City /State/Zip** |
| **Drug Name** | **Cimzia** | **Phone:**<br>**Fax:** |
| **Dose and Quantity** | | **NPI** |
| **Directions** | | **Contact Person** |
| **Date of Service(s)** | | **Contact Person**<br>**Phone / Ext.** |

**STEP 1: DISEASE STATE INFORMATION**

**Required Demographic Information:**

*Patient Weight:* _____*kg*

*Patient Height:* _____*ft* _____*inches*

Will the provider be administering the medication to the FEP member within the health plan's geographic service area?

❑ Yes ❑ No *If No, a prior authorization is not required through this process.*

**Prior authorizations are required for FEP members that will be serviced by a provider within the health plan's geographic service area. If you are not a provider in the geographic service area, please contact the health plan for questions regarding the FEP member's benefit requirements.**

Is this member's FEP coverage primary or secondary coverage?

❑ If primary, continue with question set.

❑ If secondary, **an authorization is not needed through this process. Please contact the member's primary coverage for determination of benefit and additional information.**

**Site of Care:**

A. At what location will the member be receiving the requested medication?

❑ Physician's office, home infusion, non-hospital affiliated ambulatory infusion center.

❑ Outpatient hospital infusion center. Please provide the name of the infusion center and rationale why the patient must receive this medication in a hospital outpatient setting. _____

_____

❑ Other. Please specify. _____

**Criteria Questions:**

1. Has the patient been on Cimzia therapy continuously for the last **6 months**, excluding samples? ***Please select answer below:***

❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 2**

❑ **NO** – this is **INITIATION** of Cimzia therapy, please answer the following questions:

2. What is the patient's diagnosis?

❑ Ankylosing Spondylitis (AS): Is the patient's ankylosing spondylitis active? ❑ Yes ❑ No

a. Has the patient had an inadequate response, intolerance or contraindication to at least 2 non-steroidal anti-inflammatory drugs (NSAIDs)? ❑ Yes ❑ No

❑ Crohn's Disease (CD): Does the patient have moderate to severe Crohn's disease?

❑ Yes ❑ No

a. Has the patient had an inadequate response, intolerance or contraindication to at least one conventional therapy option?

❑ Yes ❑ No

❑ Plaque Psoriasis (Ps): Is the plaque psoriasis moderate to severe? ❑ Yes ❑ No

a. Has the patient had an inadequate response, intolerance or contraindication to conventional systemic therapy?

***Please select answer below:***

❑ Inadequate response ❑ Intolerance or contraindication

❑ Patient has not tried conventional systemic therapy

b. Has the patient had an inadequate response, intolerance or contraindication to phototherapy? ***Please select answer below:***
❑ Inadequate response ❑ Intolerance or contraindication ❑ Patient has not tried phototherapy

c. Does the prescriber agree that the patient will be dosed within the FDA labeled maintenance dose of 400mg every other week?
❑ Yes ❑ No

❑ Psoriatic Arthritis (PsA): Is the patient's psoriatic arthritis active? ❑ Yes ❑ No

a. Has the patient had an inadequate response, intolerance or contraindication to a 3-month trial of at least one conventional DMARD? ❑ Yes ❑ No

❑ Rheumatoid Arthritis (RA): Does the patient have moderate to severely active rheumatoid arthritis?
❑ Yes ❑ No

a. Has the patient had an inadequate response, intolerance or contraindication to a 3-month trial of at least one conventional DMARD? ❑ Yes ❑ No

❑ Other diagnosis ***(please specify):*** _____

3. **Ankylosing Spondylitis, Crohn's Disease, Psoriatic Arthritis or Rheumatoid Arthritis diagnosis**: Does the prescriber agree that the patient will be dosed within the FDA labeled maintenance dose of 400 mg every 4 weeks? ❑ Yes ❑ No

4. Has the patient been tested for latent tuberculosis (TB)? ❑ Yes* ❑ No
***If YES,*** what was the result of the patient's TB test? ❑ Negative ❑ Positive*
***If POSITIVE***, is the patient currently receiving treatment or has the patient already completed treatment for TB? ❑ Yes ❑ No

5. Is the patient at risk for Hepatitis B Virus (HBV) infections? ❑ Yes* ❑ No
***If YES,*** has HBV been ruled out or has the patient already started treatment for the HBV infection? ❑ Yes ❑ No

6. Does the patient have any active infections including tuberculosis (TB) or hepatitis B virus (HBV)? ❑ Yes ❑ No

7. Will the patient be given live vaccines while on Cimzia therapy? ❑ Yes ❑ No

8. Will Cimzia be used in combination with another biologic DMARD* or targeted synthetic DMARD? ❑ Yes ❑ No
**DMARD includes: Actemra, Cosentyx, Enbrel, Entyvio, Humira, Inflectra, Kevzara, Kineret, Orencia, Otezla, Remicade, Renflexis, Rituxan, Siliq, Simponi, Stelara, Taltz, Tremfya, and Xeljanz*

**<u>Continuation of CIMZIA Therapy (PA RENEWAL)</u>**

1. Has the patient been on Cimzia therapy continuously for the last **6 months**, <u>excluding samples</u>? ***Please select answer below:***
❑ **NO** – this is **INITIATION** of Cimzia therapy, please answer the questions on **<u>PAGE 1</u>**
❑ **YES –** this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

2. What is the patient's diagnosis?
❑ Ankylosing Spondylitis (AS)
a. Does the prescriber agree that the patient will be dosed within the FDA labeled maintenance dose of 400 mg every 4 weeks?
❑ Yes ❑ No
❑ Crohn's Disease (CD)
a. Does the prescriber agree that the patient will be dosed within the FDA labeled maintenance dose of 400 mg every 4 weeks?
❑ Yes ❑ No
❑ Plaque Psoriasis (Ps)
a. Does the prescriber agree that the patient will be dosed within the FDA labeled maintenance dose of 400mg every other week?
❑ Yes ❑ No
❑ Psoriatic Arthritis (PsA)
a. Does the prescriber agree that the patient will be dosed within the FDA labeled maintenance dose of 400 mg every 4 weeks?
❑ Yes ❑ No
❑ Rheumatoid Arthritis (RA)
a. Does the prescriber agree that the patient will be dosed within the FDA labeled maintenance dose of 400 mg every 4 weeks?
❑ Yes ❑ No
❑ Other diagnosis ***(please specify):*** _____

3. Has the patient's condition improved or stabilized with therapy? ❑ Yes ❑ No

4. Does the patient have any active infections including tuberculosis (TB) or hepatitis B virus (HBV)? ❑ Yes ❑ No

5. Will the patient be given live vaccines while on Cimzia therapy? ❑ Yes ❑ No

6. Will Cimzia be used in combination with another biologic DMARD* or targeted synthetic DMARD? ❑ Yes ❑ No
**DMARD includes: Actemra, Cosentyx, Enbrel, Entyvio, Humira, Inflectra, Kevzara, Kineret, Orencia, Otezla, Remicade, Renflexis, Rituxan, Siliq, Simponi, Stelara, Taltz, Tremfya, and Xeljanz*

*Chart notes are required for the processing of all requests. Please add any other supporting medical information necessary for our review* **(required)**

**Coverage will not be provided if the prescribing physician's signature and date are not reflected on this document.**

❑ Request for expedited review: I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function

| **Physician's Name** | **Physician Signature** | **Date** |
|---|---|---|
| **Step 2:** Checklist | ❑ Form Completely Filled Out<br>❑ Provide chart notes | ❑ Attach test results |
| **Step 3:** Submit | **By Fax: BCBSM Specialty Pharmacy Mailbox**<br>**1-877-325-5979** | **By Mail: BCBSM Specialty Pharmacy Program**<br>**P.O. Box 312320, Detroit, MI 48231-2320** |