AvMed

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-877-535-1391**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Drug Requested: Cimzia™ (certolizumab) **Lyophilized (J0717) (Medical)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

- ❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

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PART A - DMARD therapy - Trial and failure of at least **ONE (1) DMARD** therapy for at least **THREE (3) months (check each tried):**

❑ methotrexate	❑ sulfasalazine	❑ azathioprine
❑ leflunomide	❑ auranofin	❑ hydroxychloroquine
❑ Other: _____		

❑ **DIAGNOSIS - Crohn's Disease.** To qualify for approval, boxes must be checked.

- ❑ Prescribed by or in consultation with a **Gastroenterologist**

AND

- ❑ Diagnosed with Crohn's disease

AND

- ❑ Failure of budesonide or high dose (40-60 mg prednisone) steroids

AND

- ❑ Member tried and failed at least **one DMARD** for at least **three (3) months (REFER TO PART A above and check each DMARD therapy tried)**

DIAGNOSIS. Check below the diagnosis that applies.	
❑ **Rheumatoid Arthritis**	❑ **Psoriatic Arthritis**

- ❑ Prescribed by or in consultation with a **Rheumatologist**

AND

- ❑ Diagnosed with one of the diagnoses above (must be checked)

AND

- ❑ Member tried and failed at least **one (1) DMARD** for at least **three (3) months (REFER TO PART A above and check each DMARD therapy tried).**

DIAGNOSIS: Check below diagnosis that applies.		
❑ **Ankylosing Spondylitis**	❑ **Axial Spondyloarthritis**	❑ **Non-Radiographic Axial Spondyloarthritis (chart notes must be included):**

- ❑ Prescribed by or in consultation with a **Rheumatologist**

AND

- ❑ Diagnosed with one of the diagnoses above (must be checked)

AND

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- ❑ Trial and failure of **two (2) NSAIDs** within the **last 60 days**

❑ **DIAGNOSIS - Plaque Psoriasis.** To qualify for approval, boxes must be checked.

- ❑ Prescribed by or in consultation with a **Dermatologist**

AND

- ❑ Diagnosed with moderate-to-severe Chronic Plaque Psoriasis

AND

- ❑ Member tried and failed **at least one** of either Phototherapy or Alternative System Therapy for at least **three (3) months** **(check each tried below)**:

❑ **Phototherapy:** ❑ **UV Light Therapy** ❑ NB UV-B ❑ PUVA	❑ **Alternative Systemic Therapy:** ❑ **Oral Medications** ❑ acitretin ❑ methotrexate ❑ cyclosporine

❑ **DIAGNOSIS – Polyarticular Juvenile Idiopathic Arthritis.** To qualify for approval, boxes must be checked.

- ❑ Diagnosed with active polyarticular **juvenile idiopathic arthritis**

AND

- ❑ Prescribed by or in consultation with a **Rheumatologist**

AND

- ❑ Member is 2 years of age or older and weighs at least 10 kg

AND

- ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**
  - ❑ cyclosporine
  - ❑ hydroxychloroquine
  - ❑ leflunomide
  - ❑ methotrexate
  - ❑ Non-steroidal anti-inflammatory drugs (NSAIDs)
  - ❑ oral corticosteroids
  - ❑ sulfasalazine
  - ❑ tacrolimus

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Medication being provided by: Please check applicable box below.

- ❑ **Location/site of drug administration:** _____
  NPI or DEA # of administering location: _____

OR

- ❑ **Specialty Pharmacy**

For urgent reviews: Practitioner should call AvMed Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. AvMed's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.*

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

***Approved by Pharmacy & Therapeutics Committee**: ~~9/17/2009;~~ **11/21/2024**
REVISED/UPDATED/REFORMATTED: ~~6/3/2011; 8/12/2011; 11/29/2011; 7/9/12; 8/1/2013; 1/16/2014; 2/7/2014; 4/28/2014; 8/8/2014; 10/31/2014; 2/6/2015; 4/3/2015; 5/23/2015; 1/29/2016; 3/31/2016; 8/17/2016; 9/22/2016; 12/28/2016; 2/8/2017; 7/24/2017; 4/30/2018; 11/20/2018; 4/9/2019 4/11/2019;4/26/2019; 5/7/2019; 7/6/2019; 9/16/2019; 12/17/2024;~~ **04/30/2025**