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? ☐ Yes ☐ No
2. Is the medication being requested to treat an FDA-approved indication not otherwise excluded from Part D? ☐ Yes ☐ No
   Diagnosis: _________________________ ICD-9 code_________
3. Does the patient have moderately to severely active Crohn's disease? ☐ Yes ☐ No
   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))? ☐ Yes ☐ No
4. Was the patient evaluated for latent tuberculosis infection with a PPD tuberculin test? ☐ Yes ☐ No
   If yes:
   - Did the patient have a positive PPD tuberculin test? ☐ Yes ☐ No
   - If yes, is the patient being treated for latent tuberculosis? ☐ Yes ☐ No

5. Does the patient have an active infection, including chronic and localized infections? ☐ Yes ☐ 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? ☐ Yes ☐ No
7. Has the patient been assessed for risk of active hepatitis B infection? ☐ Yes ☐ No

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