Prior Authorization Request
Nevada Medicaid – Molina Healthcare

Cimzia® (certolizumab pegol)

Please provide the information below. Please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request. **FAX responses to: (844) 259-1689. Phone: (833) 685-2103.**

DATE OF REQUEST:		
MEMBER INFORMATION		
Last Name, First Name, Middle Initial:		Date of Birth:
Molina ID:	Gender: ☐ Male ☐ Female	Phone:
PRESCRIBING PROVIDER INFORMATION		
Name:	NPI:	Specialty:
Phone:	Fax (required):	
Person to contact regarding this request:		
DIAGNOSIS AND REQUESTED DRUG		
Name: **Cimzia**	Strength:	
Dosage:	Duration:	

Please document the recipient's diagnosis:
☐ Crohn's Disease ☐ Rheumatoid Arthritis ☐ Other:_____

CLINICAL INFORMATION

Check the applicable boxes to indicate each item as true for the recipient:

☐ The recipient has had a rheumatology consult. Date:_____ Duration of disease:_____ **(if applicable)**.
☐ The recipient has fistulizing Crohn's disease **(Crohn's disease only)**.
☐ The recipient has mild disease activity.
☐ The recipient has moderate disease activity.
☐ The recipient has high/severe disease activity.
☐ The recipient does not have moderate to severe heart failure (NYHA class III or IV).
☐ The recipient does not have a history of treated lymphoproliferative disease in the previous 5 years.
☐ The recipient does not have acute or chronic liver disease classified as Child-Pugh class B or C.
☐ The recipient does not have multiple sclerosis or another demyelinating disorder.
☐ The recipient does not have an active infection or history of recurring infections.
☐ The recipient has had a negative tuberculin test prior to initiating requested treatment.
☐ The recipient has had a positive tuberculin test prior to initiating requested treatment.
☐ Treatment with isoniazid was started ≥1 month prior to initiating requested treatment **(only if test was positive)**.

List the medications that were tried and failed for the given diagnosis:

Drug Name	**Reason for Failure**	**Date(s)**

Additional clinical information (if applicable):

PROVIDER CERTIFICATION – *Prescriber's signature and date required.*

I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Nevada Medicaid.

Prescriber's Signature: _____ **Date:** _____

*Authorization will not be given for the use of more than one biologic at a time (combination therapy).