Medical drug benefit
Prior authorization request

WellSense HEALTH PLAN

Cimzia
Version20 Effective: 06/23/2023

Phone: 877-417-1839 (NH Medicaid)

Fax: 866-539-7185

* Some plans might not accept this form for Medicare or Medicaid requests

This form is being used for:	
Check if Expedited Review/Urgent Request:	☐ (In checking this box, I attest to the fact that this request meets the definition and criteria for expedited review and is an urgent request.)

1. Patient information	
Patient Name:	DOB:
Member ID #:	

2. Prescriber information	
Prescribing Clinician:	Phone #:
Specialty:	Secure Fax #:
NPI #:	DEA/xDEA:
Prescriber Point of Contact Name (POC) (if different than provider):	
POC Phone #:	POC Secure Fax #:
POC Email (not required):	
Prescribing Clinician or Authorized Representative Signature:	Date:

3. Requested dosing

Please document the requested dosing:

4. Concurrent use

Will the member be using the requested medication concurrently with a biologic or a targeted synthetic DMARD?

☐ Yes

☐ No

5. Diagnosis

Please choose the appropriate diagnosis:

☐ Ankylosing Spondylitis (Proceed to Q12)

☐ Crohn's Disease (Proceed to Q6)

☐ Non-Radiographic Axial Spondyloarthritis (Proceed to Q7)

☐ Plaque Psoriasis (Proceed to Q9)

☐ Psoriatic Arthritis (Proceed to Q12)

☐ Rheumatoid Arthritis (Proceed to Q10)

☐ Spondyloarthritis, Other Subtypes (Proceed to Q11)

☐ Other, please indicate diagnosis below and include supporting clinical documentation for use in this indication and attached applicable chart notes in faxed request

6. For Crohn's disease

Please choose **all** of the following that apply: (Proceed to Q12)

☐ Member has tried or is currently taking systemic corticosteroids, or corticosteroids are contraindicated

☐ Member has tried one other conventional systemic therapy for Crohn's disease (e.g. azathioprine, 6-mercaptopurine, or methotrexate)

☐ Member has enterocutaneous (perianal or abdominal) or rectovaginal fistulas

☐ Member had ileocolonic resection

☐ Other (please specify):

7. For Non-Radiographic Axial Spondyloarthritis

Does the member have objective signs of inflammation? (Proceed to Q8)

☐ Yes

☐ No

8. For Non-Radiographic Axial Spondyloarthritis

Please choose all of the following that apply: (Proceed to Q12)

☐ C-reactive protein (CRP) is elevated beyond the upper limit of normal

☐ Sacroiliitis is reported on magnetic resonance imaging

☐ Other, please specify:

9. For Plaque Psoriasis

Please select **all** that apply:

☐ Member has tried at least one traditional systemic agent for at least 3 months, or has an intolerance (e.g. methotrexate, cyclosporine, acitretin tablets, or psoralen plus ultraviolet A light (PUVA)

☐ Other (please specify):

10. For Rheumatoid Arthritis

Please choose all of the following that apply (Proceed to Q12):

☐ Member has tried ONE conventional synthetic DMARD for at least 3 months (e.g. methotrexate, leflunomide, hydroxychloroquine, and sulfasalazine)

☐ Other (please specify):

11. For Spondyloarthritis

Please choose **all** of the following that apply (proceed to Q12)

☐ Member has arthritis primarily in the knees, ankles, elbows, wrists, hands, and/or feet

☐ Member has tried at least one conventional synthetic DMARD (e.g. methotrexate, leflunomide, and sulfasalazine)

☐ Other (please specify):

12. Specialty of the prescriber

Please indicate what specialty the prescriber is (select any that apply):

☐ Dermatologist

☐ Gastroenterologist

☐ Rheumatologist

☐ Other (please indicate what specialty below):

13. Initial or continuing therapy

Is the request for initial or continuing therapy?

☐ Initial (Proceed to Q18)

☐ Continuation (Proceed to Q14)

14. Diagnosis

Please select the appropriate diagnosis

☐ Ankylosing Spondylitis (Proceed to Q15)

☐ Crohn's disease (proceed to Q15)

☐ Non-radiographic Axial Spondylitis (Proceed to Q15)

☐ Plaque psoriasis (proceed to Q16)

☐ Rheumatoid arthritis (proceed to Q15)

15. For Ankylosing Spondylitis, Crohn's disease, Non-Radiographic Axial Spondyloarthritis, Psoriatic Arthritis, Rheumatoid Arthritis or Spondyloarthritis, Other Subtypes

Please choose **all** of the following that apply:

☐ Member has been established on therapy for at least 6 months

☐ When assessed by at least one objective measure, member experienced a beneficial clinical response from baseline

☐ Member experienced an improvement in at least one symptom compared to baseline

☐ Other (please specify):

16. Plaque Psoriasis

Please choose **all** of the following that apply:

☐ Member has been established on the requested drug for at least 90 days

☐ Member experienced a beneficial clinical response from baseline in estimated body surface area, erythema, induration/thickness, and/or scale of areas affected by psoriasis

☐ Member experienced an improvement in at least one symptom compared to baseline

17. Improvement(s) in symptoms from baseline

Please choose the appropriate improvement(s):

☐ Decreased pain	☐ Decreased stiffness
☐ Decreased fatigue	☐ Decreased itching or burning
☐ Decreased stool frequency	☐ Decreased blood in stool
☐ Decreased joint pain or morning stiffness	☐ Decreased soft tissue swelling in joint or tendon sheaths
☐ Improvement in function or activities of daily living	
☐ Other (please specify):	

18. HCPCS Codes

Please document the applicable HCPCS codes (e.g. J codes or Q codes) being requested, including the number of units and number of visits *(using the space below):*

☐ HCPCS / Qcodes:

☐ Number of units:

☐ Number of visits:

Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers may attach any additional data relevant to medical necessity criteria.