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 ❑Male ❑Female	**Address**
Diagnosis		**City /State/Zip**
Drug Name	**Cimzia**	**Phone:** **Fax:**
Dose and Quantity		**NPI**
Directions		**Contact Person**
Date of Service(s)		**Contact Person** **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 continuation section.
   - ❑ **NO** – this is **INITIATION** of Cimzia therapy, please answer the following questions:
2. Has the patient been tested for latent tuberculosis (TB)? ❑Yes* ❑ No
   - ***If YES,*** was the result of the test positive or negative for TB infection? ❑ Negative ❑ Positive*
     - ***If POSITIVE***, has the patient completed treatment or is the patient currently receiving treatment for latent TB? ❑Yes ❑No
3. Does the patient have any active infections including tuberculosis (TB) or hepatitis B virus (HBV)? ❑Yes ❑No
4. 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 HBV infection? ❑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
   - ***If YES***, please specify medication: _____
   - ****DMARDs: Actemra, Avsola, Bimzelx, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR***
7. What is the patient's diagnosis?
   - ❑ Ankylosing Spondylitis (AS)
     - a. Does the patient have active ankylosing spondylitis? ❑Yes ❑No
     - b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least two non-steroidal anti-inflammatory drugs (NSAIDs)? ❑Yes ❑No
     - c. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 400mg every 4 weeks? ❑Yes ❑No
   - ❑ Moderate to Severe Crohn's Disease (CD)
     - a. Does the patient have moderate to severe Crohn's disease? ❑Yes ❑No
     - b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one conventional therapy option? ❑Yes ❑No
     - c. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 400mg every 4 weeks? ❑Yes ❑No
   - ❑ Non-radiographic axial spondyloarthritis (nr-axSpA)
     - a. Does the patient have active non-radiographic axial spondyloarthritis? ❑Yes ❑No
     - b. Does the patient have objective signs of inflammation? ❑Yes ❑No
     - c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least two non-steroidal anti-inflammatory drugs (NSAIDs)? ❑Yes ❑No
     - d. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 400mg every 4 weeks? ❑Yes ❑No
   - ❑ Plaque psoriasis (PsO)
     - a. Does the patient have moderate to severe plaque psoriasis? ❑Yes ❑No
     - b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to conventional systemic therapy? ***Please select answer below:***
       - ❑Inadequate response ❑Intolerance or contraindication ❑Patient has not tried conventional systemic therapy
     - c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to phototherapy? ***Please select answer:***
       - ❑Inadequate response ❑Intolerance or contraindication ❑Patient has not tried phototherapy
     - d. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 400mg every other week? ❑Yes ❑No
   - ❑ Psoriatic arthritis (PsA)
     - a. Does the patient have active psoriatic arthritis? ❑Yes ❑No
     - b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3-month trial of at least one conventional disease modifying antirheumatic drug (DMARD)? ❑Yes ❑No
     - c. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 400mg every 4 weeks? ❑Yes ❑No
   - ❑ Rheumatoid arthritis (RA)
     - a. Does the patient have moderate to severely active rheumatoid arthritis? ☐Yes ☐No
     - b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3-month trial of at least one conventional disease modifying antirheumatic drug (DMARD)? ❑Yes ❑No
   - ❑ Polyarticular juvenile idiopathic arthritis (pJIA)
     - a. Does the patient have active polyarticular juvenile idiopathic arthritis (pJIA)? ❑Yes ❑No
     - b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3-month trial of at least one conventional disease modifying antirheumatic drug (DMARD)? ❑Yes ❑No
     - c. **Age 2-17**: What is the patient's weight? ***Please select answer below:***
       - ❑**Less than 10 kg (22 lbs)**
       - ❑**10 kg (22 lbs) to less than 20 kg (44 lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 50mg every other week? ❑Yes ❑No
       - ❑**20 kg (44 lbs) to less than 40 kg (88 lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 100mg every other week? ❑Yes ❑No
       - ❑**40 kg (88 lbs) or more**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 200mg every other week? ❑Yes ❑No
     - d. **Age 18 or older**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 200mg every other week? ❑Yes ❑No
   - ❑ Other diagnosis ***(please specify):*** _____

CONTINUATION OF THERAPY (PA RENEWAL)

1. Has the patient been on Cimzia therapy continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   - ❑ **NO** – this is **INITIATION** of Cimzia therapy, please answer the questions on initiation section.
   - ❑ **YES –** this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:
2. Has the patient's condition improved or stabilized with Cimzia? ❑Yes ❑No
3. Does the patient have any active infections including tuberculosis (TB) or hepatitis B virus (HBV)? ❑Yes ❑No
4. Will the patient be given live vaccines while on Cimzia therapy? ❑Yes ❑No
5. Will Cimzia be used in combination with another biologic DMARD* or targeted synthetic DMARD? ❑Yes ❑No

   If YES, please specify medication: _____

   DMARDs: Actemra, Avsola, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR
6. What is the patient's diagnosis?
   - ❑ Ankylosing spondylitis (AS)
     a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 400mg every 4 weeks? ❑Yes ❑No
   - ❑ Crohn's disease (CD)
     a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 400mg every 4 weeks? ❑Yes ❑No
   - ❑ Non-Radiographic Axial Spondyloarthritis (nr-axSpA)
     a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 400mg every 4 weeks? ❑Yes ❑No
   - ❑ Plaque Psoriasis (Ps)
     a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 400mg every other week? ❑Yes ❑No
   - ❑ Psoriatic Arthritis (PsA)
     a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 400mg every 4 weeks? ❑Yes ❑No
   - ❑ Polyarticular juvenile idiopathic arthritis (pJIA)
     a. **Age 2-17**: What is the patient's weight? ***Please select answer below:***
        - ❑**Less than 10 kg (22 lbs)**
        - ❑**10 kg (22 lbs) to less than 20 kg (44 lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 50mg every other week? ❑Yes ❑No
        - ❑**20 kg (44 lbs) to less than 40 kg (88 lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 100mg every other week? ❑Yes ❑No
        - ❑**40 kg (88 lbs) or more**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 200mg every other week? ❑Yes ❑No

     b. **Age 18 or older**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 200mg every other week? ❑Yes ❑No
   - ❑ Rheumatoid Arthritis (RA)
     a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 400mg every 4 weeks? ❑Yes ❑No
   - ❑ Other diagnosis ***(please specify):*** _____

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 ❑ Provide chart notes	❑ Attach test results
Step 3: Submit	**By Fax: BCBSM Specialty Pharmacy Mailbox** **1-877-325-5979**	**By Mail: BCBSM Specialty Pharmacy Program** **P.O. Box 312320, Detroit, MI 48231-2320**