Washington State Health Care Authority

# CIMZIA (Certolizumab pegol. Inj.) J0717 Request

Please Fax Response to: 1-866-668-1214 Medical Request Coordinator

Please provide the information below. Please print your answers, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request.

**Without this information, the request may be denied in 30 days.**

| Date of request | Reference number | MAS |
|---|---|---|
| Patient | Date of birth | ProviderOne Client ID |
| Prescriber | Telephone number | Fax number |
| Drug/Strength | Directions for use | Quantity / Days supply |

Procedure/HCPC Code: **J0717**

Certolizumab is considered medically necessary when prescribed according to FDA labeling and **one** of the following conditions applies:

- Treatment of Crohn's disease when prescribed by a gastroenterologist. Must have tried and failed adalimumab (Humira);
- Treatment of ankylosing spondylitis, psoriatic arthritis, or rheumatoid arthritis when prescribed by a rheumatologist. Must have tried and failed both etanercept (Enbrel) and adalimumab (Humira).

1. What is the diagnosis:

   ☐ Crohn's disease ☐ Rheumatoid arthritis ☐ Ankylosing spondylitis ☐ Psoriatic arthritis

   ☐ Other, please specify

2. What alternative medication(s) have been tried? What were the outcomes? What was the duration of each treatment?

3. If no other medication has been tried please explain why not?

4. If the requested dose is > 400mg per 28 days, please provide justification and/or peer-reviewed medical literature providing evidence of safety and efficacy for dosing greater than the FDA approved dose of 400mg initially and at weeks 2 and 4, followed by either 200mg every two weeks or 400mg every four weeks.

5. Additional information:

## Please attach supporting objective clinical documentation

| Prescriber signature | Prescriber Specialty | Date |
|---|---|---|

**To submit your request:**

**A copy of the prescription must be attached.**

**A typed and completed *General Authorization for Information* form (13-835) must be the first page to your request.**

Fax to: **1-866-668-1214**
Or mail to: Medical Request Coordinator
PO Box 45535
Olympia, WA 98504-5535