TEXAS MEDICAID
Clinical Edit Prior Authorization
certolizumab pegol (CIMZIA)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:
STEP 2: MEDICATION INFORMATION	
Medication Requested (Name):	Quantity Requested:
Dose Requested:	Dosing Instructions:

Patient's Primary Diagnosis: _____ ICD 10 Code: _____

Please indicate ONE (1) of the following:

☐ STAR / STAR KIDS client **(Go to Step 3 - PDL PA Criteria Applies)**

OR ☐ CHIP / PERINATE client **(Go to Step 4)**

STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the last 180 days?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #2)

2. Is there a documented allergy or contraindication to preferred agents in this class?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Deny)

STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Is the client greater than or equal to (≥) 18 years of age?

   ☐ Yes (Go to #2) ☐ No (Deny)

2. Does the client have a diagnosis of Crohn's disease (CD) in the last 730 days?

   ☐ Yes (Go to #3) ☐ No (Go to #4)

3. Has the client had a 30-day treatment trial of conventional therapy for Crohn's disease in the last 180 days?

   ☐ Yes (Go to #5)

   ☐ No – And the request is for continuing therapy (Go to #5)

   ☐ No – And the request is for initial therapy (Go to #4)

4. Does the client have a diagnosis of at least ONE (1) of the following in the last 730 days?

   - Ankylosing Spondylitis (AS)
   - Non-Radiographic Axial Spondyloarthritis
   - Plaque Psoriasis (Ps)
   - Psoriatic Arthritis (PsA)
   - Rheumatoid Arthritis (RA)

   ☐ Yes (Go to #5) ☐ No (Deny)

5. Does the client have a history of a demyelinating disease (multiple sclerosis, optic neuritis, Guillain-Barre syndrome) in the last 365 days?

   ☐ Yes (Deny) ☐ No (Go to #6)

6. Does the client have a history of heart failure in the last 365 days?

   ☐ Yes (Deny) ☐ No (Go to #7)

7. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

   ☐ Yes (Deny) ☐ No (Go to #8)

8. Does the client have a history of hematologic abnormalities such as aplastic anemia, pancytopenia, thrombocytopenia, neutropenia, or decreased white blood cell counts in the last 60 days?

   ☐ Yes (Deny) ☐ No (Go to #9)

9. Does the client have one (1) claim for a contraindicated drug in the last 30 days?

   Contraindicated drugs include KINERET, ORENCIA, RITUXAN, and TYSABRI.

   ☐ Yes (Deny) ☐ No (Approve – 365 days)

STEP 5: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.