



Department of Vermont Health Access  
NOB 1 South, 280 State Drive  
Waterbury, Vermont 05671-1010

~Cimzia~

## Prior Authorization Request Form

In order for beneficiaries to receive Medicaid coverage for medications that require prior authorization, the prescriber must complete and fax this form to Change Healthcare. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information. For questions, please contact the Change Healthcare helpdesk at 1-844-679-5363.

**Submit request via Fax: 1-844-679-5366**

### Prescribing physician:

Name: \_\_\_\_\_  
Physician NPI: \_\_\_\_\_  
Specialty: \_\_\_\_\_  
Phone#: \_\_\_\_\_  
Fax#: \_\_\_\_\_  
Address: \_\_\_\_\_  
Contact Person at Office: \_\_\_\_\_

### Beneficiary:

Name: \_\_\_\_\_  
Medicaid ID#: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_  
Patient's Phone: \_\_\_\_\_  
Pharmacy Name: \_\_\_\_\_  
Pharmacy NPI: \_\_\_\_\_  
Pharmacy Phone: \_\_\_\_\_ Pharmacy Fax: \_\_\_\_\_

### The following **MUST** be completed for MEDICAL BENEFIT requests:

HCPCS J-code or other code: \_\_\_\_\_

Administering Provider/Facility: Name \_\_\_\_\_ NPI# \_\_\_\_\_ Medicaid ID# \_\_\_\_\_

### Patient Diagnosis:

☐ Rheumatoid Arthritis ☐ Psoriatic Arthritis ☐ Ankylosing Spondylitis ☐ Crohn's Disease

### List previous medications/therapies tried and failed for this condition: (include oral/injectable, topical, phototherapy etc.)

Name of medication	Type of failure	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

### Dosage Form and Quantity:

☐ Cimzia 200mg/1ml prefilled syringe (kit) Dispense Quantity: 1 (2 syringes)  
☐ Cimzia 200mg lyophilized vial (kit) (for Health Care Professional administration) Dispense Quantity: 1 (2 vials)  
☐ Cimzia 200mg/1ml prefilled syringe (Starter kit-6) Dispense Quantity 1 (6 syringes)  
400mg (given as two subcutaneous injections of 200mg) initially, and at Weeks 2 and 4

### Sig: Dose/Route/Frequency

☐ As above  
☐ 400mg (given as two subcutaneous injections of 200mg) every four weeks  
(Crohn's, RA, PsA, or AS)  
☐ 200mg (given as one subcutaneous injection) every two weeks (RA, PsA, AS)

Prescribers Additional Comments: \_\_\_\_\_

**Deliver product to:** ☐ Patient's home ☐ MD office ☐ Clinic

By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and/or recoupment.

**Prescriber's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

