VERMONT

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#_____

Please check box if this drug is being provided under the DVHA's 340B Drug program and requires the TB modifier ☐

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:** _____

CHANGE HEALTHCARE