aetna®

Cimzia® (certolizumab) Injectable Medication Precertification Request

(Please complete all fields and return both pages for precertification of medications.)

Aetna Precertification Notification
Phone: 1-855-240-0535
FAX: 1-877-269-9916

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:
Patient Current Weight: _____ lbs or _____ kgs	Patient Height: _____ inches or _____ cms	Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Gastroenterologist** ☐ **Rheumatologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Cimzia (certolizumab): ☐ Prefilled Syringe ☐ Vials (Please fax request for Vials to 1-888-267-3277)
Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other any other where applicable (*).

Primary ICD code: _____ Secondary ICD code: _____ Other: _____

G. CLINICAL INFORMATION - Required clinical information must be completed for ALL precertification requests.

For initiation requests (clinical documentation required):

☐ Yes ☐ No Will certolizumab (Cimzia) be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?

☐ Yes ☐ No Has the patient been tested for TB with a PPD test, interferon-release assay (IGRA) or chest x-ray within 6 months of initiating a biologic therapy?
→ (check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray
Please enter the date and results of the TB test: Date: ____/____/____ Results: ☐ Positive ☐ Negative ☐ Unknown
If positive, Does the patient have latent or active TB? ☐ Latent ☐ Active
If latent TB, ☐ Yes ☐ No Will TB treatment be started before initiation of therapy with certolizumab (Cimzia)?

Ankylosing Spondylitis

☐ Yes ☐ No Is there evidence that the disease is active?

☐ Yes ☐ No Has the patient had an inadequate response to two or more non-steroidal anti-inflammatory drugs (NSAIDs)?
→ Please provide the names and date ranges: NSAID #1: _____ Date range: ____/____/____ to ____/____/____
NSAID #2: _____ Date range: ____/____/____ to ____/____/____

Crohn's Disease

What is the severity of the patient's Crohn's disease? ☐ Mild ☐ Moderate ☐ Severe

☐ Yes ☐ No Does the patient have a documented diagnosis of active Crohn's disease?
→ Check all signs/symptoms that apply:
☐ abdominal pain ☐ arthritis ☐ bleeding ☐ diarrhea ☐ internal fistulae ☐ intestinal obstruction
☐ megacolon ☐ perianal disease ☐ spondylitis ☐ weight loss ☐ None of the above

☐ Yes ☐ No Have the Crohn's disease symptoms remained active despite treatment with either 6-mercaptopurine, azathioprine, or corticosteroids?
→ Please check all medications that apply: ☐ 6-mercaptopurine ☐ azathioprine ☐ corticosteroids
Please provide name of medication tried: Name: _____ Date range: ____/____/____ to ____/____/____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *[Section 1] (continued)*

Psoriatic Arthritis

☐ Yes ☐ No Is there evidence that the disease is active?

☐ Yes ☐ No Does the patient have **axial** psoriatic arthritis?

→ ☐ Yes ☐ No Was the treatment with 2 or more non-steroidal anti-inflammatory drugs (NSAIDs) ineffective?

→ Provide the names and date ranges: NSAID #1: _____ Date range: ___/___/___ to ___/___/___

NSAID #2: _____ Date range: ___/___/___ to ___/___/___

☐ Yes ☐ No Does the patient have **non-axial** psoriatic arthritis?

→ ☐ Yes ☐ No Was the treatment with methotrexate ineffective? ***If yes***, Date range: ___/___/___ to ___/___/___

☐ Yes ☐ No Was the treatment with methotrexate not tolerated or contraindicated? ☐ not tolerated ☐ contraindicated

→ ☐ Yes ☐ No Was a trial with at least 1 conventional disease-modifying anti-rheumatic drug (DMARD) (other than methotrexate) ineffective?

Name: _____ Date range: ___/___/___ to ___/___/___

Rheumatoid Arthritis

Please indicate the severity of the patient's rheumatoid arthritis: ☐ Mild ☐ Moderate ☐ Severe

☐ Yes ☐ No Is there evidence that the disease is active?

☐ Yes ☐ No Will Cimzia be used as monotherapy or in combination with methotrexate? ☐ Monotherapy ☐ In combination with methotrexate

☐ Other: Please explain: _____

For Continuation of Therapy (clinical documentation required for all requests):

Please indicate the length of time on certolizumab (Cimzia): _____

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of certolizumab (Cimzia)? (Sampling of Cimzia does not guarantee coverage under the provisions of the pharmacy benefit)

☐ Yes ☐ No Will certolizumab (Cimzia) be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?

☐ Yes ☐ No Is there clinical documentation supporting disease stability?

☐ Yes ☐ No Is there clinical documentation supporting disease improvement?

☐ Yes ☐ No Does the patient have any risk factors for TB?

→ ☐ Yes ☐ No Has the patient had a TB test within the past year?

(check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray

Please enter the date and results of the TB test: Date: ___/___/___ Results: ☐ Positive ☐ Negative ☐ Unknown

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ___/___/___

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.