Cimzia® (certolizumab pegol) Injectable Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

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** ☐ Dermatologist ☐ **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): _____

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

E. PRODUCT INFORMATION

Request is for Cimzia (certolizumab pegol) Dose: _____ **Frequency:** _____

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

Primary ICD code: _____ **Secondary ICD code**: _____

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

For All Requests (clinical documentation required for all requests):

☐ Yes ☐ No Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic disease-modifying anti-rheumatic drug (DMARD) (e.g., Olumiant, Otezla, Xeljanz)?

☐ Yes ☐ No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic DMARD (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis?

→ ☐ Yes ☐ No Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [PPD], interferon-release assay [IGRA], chest x-ray) within 6 months of initiating therapy?

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

Please enter the results of the tuberculosis (TB) test: ☐ positive ☐ negative ☐ unknown

If positive, please indicate which applies to the patient:

☐ latent TB and treatment for latent TB has been initiated
☐ latent TB and treatment for latent TB has been completed
☐ latent TB and treatment for latent TB has not been initiated
☐ active TB

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G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

For Initiation Requests (clinical documentation required for all requests):

Ankylosing spondylitis and axial spondyloarthritis

Please indicate loading dose at weeks 0, 2 and 6: _____ Please indicate maintenance dose: _____ frequency: _____weeks

Please select which of the following applies to the patient: ☐ Active ankylosing spondylitis (AS) ☐ Active axial spondyloarthritis

☐ Yes ☐ No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for active ankylosing spondylitis or active axial spondyloarthritis?
→ ☐ Yes ☐ No Has the patient experienced an inadequate response with at least TWO nonsteroidal anti-inflammatory drugs (NSAIDs), or does the patient have an intolerance or contraindication to at least two NSAIDs?

☐ Yes ☐ No Is the patient female and currently pregnant or breastfeeding?
→ Please indicate the preferred alternatives for ankylosing spondylitis (AS) or axial spondyloarthritis that have been ineffective, not tolerated, or are contraindicated: ☐ Cosentyx ☐ Enbrel ☐ Humira

Crohn's disease

Please indicate loading dose at weeks 0, 2, and 6: _____ Please indicate maintenance dose: _____ frequency: _____weeks

☐ Yes ☐ No Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)?

☐ Yes ☐ No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for moderately to severely active Crohn's disease?
→ ☐ Yes ☐ No Has the patient tried and had an inadequate response to at least one conventional therapy option?
→ ☐ Yes ☐ No Does the patient have a contraindication or intolerance to at least one conventional therapy option (e.g., azathioprine [Azasan, Imuran], budesonide [Entocort EC], ciprofloxacin [Cipro], mercaptopurine [Purinethol], methylprednisolone [Solu-Medrol], methotrexate IM or SC, metronidazole [Flagyl], prednisone, sulfasalazine [Azulfidine, Sulfazine], rifaximin [Xifaxan], tacrolimus)?
→ Please select: ☐ Sulfasalazine (Azulfidine, Sulfazine) ☐ Metronidazole (Flagyl) ☐ Ciprofloxacin (Cipro) ☐ Prednisone ☐ Budesonide (Entocort EC) ☐ Azathioprine (Azasan, Imuran) ☐ Mercaptopurine (Purinethol) ☐ Methotrexate IM or SC ☐ Methylprednisolone (Solu-Medrol) ☐ Rifaximin (Xifaxan) ☐ Tacrolimus

☐ Yes ☐ No Is the patient female and currently pregnant or breastfeeding?
→ Please indicate the preferred alternatives for Crohn's disease that have been ineffective, not tolerated, or are contraindicated: ☐ Humira

Plaque psoriasis

Please indicate loading dose at weeks 0, 2 and 4: _____ Please indicate maintenance dose: _____ frequency: _____weeks

☐ Yes ☐ No Has the patient been diagnosed with moderate to severe plaque psoriasis?

☐ Yes ☐ No Has the patient ever received (including current utilizers) Otezla or a biologic (e.g., Humira) indicated for the treatment of moderate to severe plaque psoriasis?
→ ☐ Yes ☐ No Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected?
→ Please indicate the percentage of body surface area (BSA) affected (prior to starting the requested medication): _____%

If less than 10% of BSA:
☐ Yes ☐ No Has the patient experienced an inadequate response, or has an intolerance to phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine or acitretin?
→ ☐ Yes ☐ No Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine and acitretin?
→ Please indicate clinical reason to avoid pharmacologic treatment:
☐ Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease
☐ Breastfeeding ☐ Cannot be used due to risk of treatment-related toxicity ☐ Drug interaction
☐ Pregnancy or currently planning pregnancy
☐ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension)
☐ Other, please explain: _____

☐ Yes ☐ No Is the patient female and currently pregnant or breastfeeding?
→ Please indicate the preferred alternatives for plaque psoriasis that have been ineffective, not tolerated, or are contraindicated:
☐ Humira ☐ Ilumya ☐ Otezla ☐ Skyrizi ☐ Stelara ☐ Taltz ☐ Tremfya

Psoriatic arthritis

Please indicate loading dose at weeks 0, 2 and 4: _____ Please indicate maintenance dose: _____ frequency: _____weeks

☐ Yes ☐ No Has the patient been diagnosed with active psoriatic arthritis (PsA)?

☐ Yes ☐ No Does the patient have psoriatic arthritis with co-existent plaque psoriasis?

☐ Yes ☐ No Is the patient female and currently pregnant or breastfeeding?
→ Please indicate the preferred alternatives for psoriatic arthritis that have been ineffective, not tolerated, or are contraindicated:
☐ Cosentyx ☐ Enbrel ☐ Humira ☐ Otezla

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G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

Rheumatoid arthritis

Please indicate loading dose at weeks 0, 2 and 6: _____ Please indicate maintenance dose: _____ frequency: _____weeks

☐ Yes ☐ No Has the patient been diagnosed with moderately to severely active rheumatoid arthritis (RA)?

☐ Yes ☐ No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic disease modifying drug (DMARD) (e.g., Rinvoq, Xeljanz) indicated for moderately to severely active rheumatoid arthritis?

→ ☐ Yes ☐ No Does the patient meet either of the following: a) the patient was tested for the rheumatoid factor (RF) biomarker and the RF biomarker test was positive, or b) the patient was tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker and the anti-CCP biomarker test was positive?

→ ☐ Yes ☐ No Has the patient been tested for all of the following biomarkers: a) rheumatoid factor (RF), b) anti-cyclic citrullinated peptide (anti-CCP), and c) C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR)?

☐ Yes ☐ No Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate at a dose greater than or equal to 15 mg per week?

→ ☐ Yes ☐ No Has the patient experienced an intolerance to methotrexate?

→ ☐ Yes ☐ No Does the patient have a contraindication to methotrexate?

→ Please indicate the contraindication:

☐ History of intolerance or adverse event ☐ Renal impairment ☐ Hypersensitivity
☐ Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
☐ Breastfeeding ☐ Elevated liver transaminases ☐ Myelodysplasia
☐ Interstitial pneumonitis or clinically significant pulmonary fibrosis
☐ Pregnancy or currently planning pregnancy ☐ Significant drug interaction
☐ Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease
☐ Other: _____

☐ Yes ☐ No Is the patient female and currently pregnant or breastfeeding?

→ Please indicate the preferred alternatives for rheumatoid arthritis have been ineffective, not tolerated, or are contraindicated:

☐ Enbrel ☐ Humira ☐ Kevzara ☐ Rinvoq ☐ Xeljanz/Xeljanz XR

For Continuation Requests (clinical documentation required for all requests):

Please indicate maintenance dose: _____ frequency: _____weeks

☐ Yes ☐ No Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

☐ Yes ☐ No Has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms since starting treatment with the requested drug?

Ankylosing spondylitis and axial spondyloarthritis

Please indicate which of the following has the patient experienced:

☐ Functional status ☐ Total spinal pain ☐ Inflammation (e.g., morning stiffness) ☐ None of the above

Crohn's disease

☐ Yes ☐ No Has the patient achieved or maintained remission?

Please indicate which of the following has the patient experienced:

☐ Abdominal pain or tenderness ☐ Abdominal mass ☐ Body weight ☐ Diarrhea ☐ Endoscopic appearance of the mucosa ☐ Hematocrit
☐ Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index [CDAI] score) ☐ None of the above

Plaque psoriasis

☐ Yes ☐ No Has the patient experienced a reduction in body surface area (BSA) affected from baseline?

→ ☐ Yes ☐ No Has the patient experienced an improvement in signs and symptoms of the condition from baseline (e.g., itching, redness, flaking, scaling, burning, cracking, pain)?

Psoriatic arthritis

Please indicate which of the following has the patient experienced:

☐ Number of swollen joints ☐ Number of tender joints ☐ Dactylitis ☐ Enthesitis ☐ Skin and/or nail involvement ☐ None of the above

Rheumatoid arthritis

Please indicate the percent of disease activity improvement from baseline in tender joint count, swollen joint count, pain, or disability: _____%

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.