



# MEDICARE FORM

## Cimzia® (certolizumab pegol) Injectable Medication Precertification Request

Page 1 of 3

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

For Medicare Advantage Part B:

FAX: 1-844-268-7263

PHONE: 1-866-503-0857

For other lines of business:

Please use other form.

Note: Cimzia is non-preferred.

Preferred products vary based on indication. See section G below.

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 #:	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #:	If yes, provide ID#: _____ Carrier Name: _____
Insured:	Insured: _____

Medicare:  Yes  No If yes, provide ID #: \_\_\_\_\_ Medicaid:  Yes  No If yes, provide ID #: \_\_\_\_\_

### C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> 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

<b>Place of Administration:</b> <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Home <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____ NPI: _____	<b>Dispensing Provider/Pharmacy: Patient Selected choice</b> <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Mail Order <input type="checkbox"/> Other: _____ Name: _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____ NPI: _____
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### 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: \_\_\_\_\_ Other ICD Code: \_\_\_\_\_

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

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

Note: Cimzia is non-preferred. Avsola, Entyvio, Remicade, and Simponi Aria are preferred for MA plans. For MAPD plans, Enbrel, Humira, Rinvoq, Skyrizi, and Xeljanz/Xeljanz XR are preferred. Preferred products vary based on indication.

Yes  No Has the patient had prior therapy with Cimzia (certolizumab pegol) within the last 365 days?

Yes  No Has the patient had a trial, intolerance, or contraindication to any of the following? (select all that apply)

Entyvio (vedolizumab)  Remicade (infliximab)  Avsola (infliximab-axxq)  Simponi Aria (golimumab)

Yes  No Has the patient had a trial, intolerance, or contraindication to any of the following? (select all that apply)

Enbrel (etanercept)  Humira (adalimumab)  Rinvoq (upadacitinib)  Skyrizi (risankizumab-rzaa)  Xeljanz/Xeljanz XR (tofacitinib)

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply)

Entyvio (vedolizumab)  Remicade (infliximab)  Avsola (infliximab-axxq)  Simponi Aria (golimumab)

Continued on next



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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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**G. CLINICAL INFORMATION (continued)** – Required clinical information must be completed in its entirety for all precertification requests.

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply)

- Enbrel (etanercept)  Humira (adalimumab)  Rinvoq (upadacitinib)  Skyrizi (risankizumab-rzaa)  Xeljanz/Xeljanz XR (tofacitinib)

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, Does the patient have latent or active tuberculosis TB?  latent  active  unknown

If latent tuberculosis  Yes  No Has treatment for latent tuberculosis (TB) infection been initiated or completed?

Please select:  treatment initiated  treatment completed

**For Initiation Requests (clinical documentation required):**

**Ankylosing spondylitis and axial spondyloarthritis**

Please indicate loading dose at weeks 0, 2 and 4: \_\_\_\_\_ 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?

**Crohn's disease**

Please indicate loading dose at weeks 0, 2, and 4: \_\_\_\_\_ 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 Does the patient have fistulizing 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

**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: \_\_\_\_\_

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

**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?

**Rheumatoid 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 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 Has the patient been tested for the rheumatoid factor (RF) biomarker?

Please indicate test result:  positive  negative  not completed

Yes  No Has the patient been tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker?

Please indicate test result:  positive  negative  not completed

Yes  No Has the patient been tested for the C-reactive protein (CRP) biomarker?

Please indicate test result:  positive  negative  not completed

Yes  No Has the patient been tested for the erythrocyte sedimentation rate (ESR) biomarker?

Please indicate test result:  positive  negative  not completed

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 20mg 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

Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease

Elevated liver transaminases  Significant drug interaction  Myelodysplasia  Breastfeeding

Interstitial pneumonitis or clinically significant pulmonary fibrosis

Pregnancy or currently planning pregnancy

Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)

Other, please explain: \_\_\_\_\_

**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 only**

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.