Cimzia® (certolizumab) Injectable Medication Precertification Request

(All fields must be completed and legible for Precertification Review)

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

For Medicare Advantage Part B:
Phone: 1-866-503-0857
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 #: _____	Does patient have other coverage? ☐ Yes ☐ 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):* ☐ 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 ☐ 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 for all requests):

☐ Yes ☐ No Will Cimzia (certolizumab) be given 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 (IGRAs) or chest x-ray within 6 months of initiation a biologic therapy?
→ (check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray
Please enter results of the TB test: ☐ 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 Cimzia (certolizumab)?

Ankylosing Spondylitis or Axial Spondyloarthritis (an early form of ankylosing spondylitis)
Please select which of the following applies to the patient: ☐ Ankylosing Spondylitis ☐ Axial Spondyloarthritis
☐ Yes ☐ No Is there evidence that the disease is active?
☐ Yes ☐ No Has the patient had an ineffective response to two or more non-steroidal anti-inflammatory drugs (NSAIDs)?
→ Please provide the names and length of treatment:
NSAID #1: _____
Please indicate length of treatment: ☐ less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater
NSAID #2: _____
Please indicate length of treatment: ☐ less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

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

Crohn's Disease

☐ Yes ☐ No Does the patient have a diagnosis of fistulizing Crohn's disease?
→ Please indicate how long the patient has been diagnosed with fistulizing Crohn's disease:
Please select: ☐ less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

☐ Yes ☐ No Does the patient have a diagnosis of Crohn's disease?
→ Please indicate the severity of the patient's disease: ☐ mild ☐ moderate ☐ severe

☐ Yes ☐ No Does the patient have a documented diagnosis of active Crohn's disease?
→ Please select 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 6-mercaptopurine, azathioprine, or corticosteroids?
→ Please check all medications that apply: ☐ 6-mercaptopurine ☐ azathioprine
☐ corticosteroids- please identify: ☐ prednisone ☐ hydrocortisone ☐ methylprednisolone ☐ other: _____
Please indicate the length of the medication trial: ☐ less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

Plaque Psoriasis

☐ Yes ☐ No Is there clinical documentation of chronic disease?
→ Please indicate the severity of the patient's plaque psoriasis: ☐ mild ☐ moderate ☐ severe

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

☐ Yes ☐ No Is the patient a candidate for systemic therapy or phototherapy?
→ Please select: ☐ phototherapy ☐ systemic therapy ☐ phototherapy and systemic therapy

Please provide the patient's Psoriasis Area and Severity Index (PASI) score: _____

Please indicate the percentage of body surface area affected by plaque psoriasis: _____%

☐ Yes ☐ No Does the plaque psoriasis affect sensitive areas? ***If yes***, please select: ☐ hands ☐ feet ☐ face ☐ genitals

☐ Yes ☐ No Was a trial of systemic conventional DMARD(s) (e.g., methotrexate, acitretin, or cyclosporine) ineffective?
→ ☐ Yes ☐ No Was the trial with systemic conventional DMARD(s) not tolerated?
☐ Yes ☐ No Are systemic conventional DMARD(s) contraindicated?
→ Please select: ☐ acitretin ☐ cyclosporine ☐ methotrexate ☐ mycophenolate ☐ other, please explain: _____
Please indicate the length of the medication trial: ☐ less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

☐ Yes ☐ No Was a trial with phototherapy ineffective?
→ ☐ Yes ☐ No Was the trial with phototherapy not tolerated?
☐ Yes ☐ No Is phototherapy contraindicated?
→ Please check all that apply: ☐ Psoralens (methoxsalen, trioxsalen) with UVA light (PUVA)
☐ UVB with coal tar or dithranol
☐ UVB (standard or narrow-band)
☐ Home UVB
☐ None of the above
Please indicate the length of trial: ☐ less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

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 two or more non-steroidal anti-inflammatory drugs (NSAIDs) ineffective?
→ Please provide the names and length of treatment:
NSAID #1: _____
Please indicate length of treatment: ☐ less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater
NSAID #2: _____
Please indicate length of treatment: ☐ less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

☐ Yes ☐ No Does the patient have **non-axial** psoriatic arthritis?
→ ☐ Yes ☐ No Does the patient have severe disease at presentation, defined as severe disability at onset with erosive disease involving multiple joints?
→ ☐ Yes ☐ No Was the treatment with methotrexate ineffective?
→ ☐ Yes ☐ No Was treatment with methotrexate not tolerated or contraindicated?
→ Please select: ☐ not tolerated ☐ contraindicated
☐ Yes ☐ No Was treatment with another conventional DMARD ineffective?
→ Please select: ☐ cyclophosphamide ☐ cyclosporine
☐ hydroxychloroquine ☐ leflunomide
☐ sulfasalazine ☐ other, please explain: _____
Please indicate length of treatment:
☐ less than 1 month ☐ 1 month
☐ 2 months ☐ 3 months or greater
→ Indicate length of therapy: ☐ less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

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

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 (certolizumab) be used as monotherapy or in combination with methotrexate?
→ Please select: ☐ as monotherapy ☐ in combination with methotrexate

☐ Yes ☐ No Was treatment with methotrexate ineffective?
→ ☐ Yes ☐ No Was treatment with methotrexate not tolerated or contraindicated? ☐ not tolerated ☐ contraindicated
→ ☐ Yes ☐ No Was treatment with another conventional DMARD (other than methotrexate) ineffective?
→ Please select: ☐ azathioprine ☐ hydroxychloroquine ☐ leflunomide ☐ sulfasalazine
Please indicate length of treatment: ☐ less than 1 month ☐ 1 month
☐ 2 months ☐ 3 months or greater

→ Please indicate length of the methotrexate therapy: ☐ less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

For Continuation of Therapy (clinical documentation required):

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

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

☐ Yes ☐ No Will Cimzia (certolizumab) 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 results of the TB test: ☐ positive ☐ negative ☐ unknown

For Crohn's disease, Plaque psoriasis, and Rheumatoid arthritis only:

Please indicate the severity of the disease at baseline (pretreatment with Cimzia (certolizumab)): ☐ mild ☐ moderate ☐ severe

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.