Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

# Cimzia
## (certolizumab pegol)

| PHYSICIAN INFORMATION | | | PATIENT INFORMATION | | |
|---|---|---|---|---|---|
| * Physician Name: | | | *Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.* | | |
| Specialty: | * DEA, NPI or TIN | | | | |
| Office Contact Person: | | | * Patient Name: | | |
| Office Phone: | | | * Cigna ID: | * Date of Birth: | |
| Office Fax: | | | * Patient Street Address: | | |
| Office Street Address: | | | City: | State: | Zip: |
| City: | State: | Zip: | Patient Phone: | | |

**Urgency:**
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

**Medication requested:**
☐ Cimzia 200 mg single-dose vial (NDC 50474 0700 62) ☐ Cimzia 200mg prefilled kit (NDC 50474 0710 79)
☐ Cimzia 400mg/2ml syringe kit (NDC 50474 0710 81)

Dose and Quantity: Duration of therapy: J-Code:

Frequency of administration: ICD10:

Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples of **Cimzia**, please choose "new start of therapy". ☐ new start of therapy ☐ continued therapy

**If continued therapy:**
Has your patient had a good response to therapy with this drug (such as improvement or remission)? ☐ Yes ☐ No
(if no) Please provide clinical support for the continued use of **Cimzia**:

Which applies to your patient?
☐ patient is established on this drug with previous approval by Cigna
☐ patient is established on this drug with previous approval by another health plan
☐ patient is established on this drug with regular use for more than 1 year
☐ patient was previously established on this drug, and is restarting after a break in therapy
Please provide the dates your patient has received **Cimzia**:

Besides the drug being requested, other biological drugs include Actemra, Cosentyx, Enbrel, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Rinvoq, Rituxan, Siliq, Simponi/Simponi Aria, Skyrizi, Stelara, Taltz, Tremfya, Tysabri, Xeljanz/Xeljanz XR. Which of the following best describes your patient's situation?

☐ The patient is NOT taking any other biological at this time, nor will they in the future. **Cimzia** is the only biological the patient is/will be using.
☐ The patient is currently on another biological, but this drug will be stopped and **Cimzia** will be started.
☐ The patient is currently on another biological, and **Cimzia** will be added. The patient may continue to take both drugs together.
☐ The patient is currently on BOTH **Cimzia** AND another biological.
☐ other/unknown

(if other/more than **Cimzia**) Please provide name of drug, dates taken and, if applicable, the clinical rationale for the combined use of **Cimzia** and another biologic to treat your patient's diagnosis.

**Where will this medication be obtained?**

☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
**Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

**Facility and/or doctor dispensing and administering medication:**

Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting*

Is this infusion occurring in a facility affiliated with hospital outpatient setting? ☐ Yes ☐ No

If yes- Is this patient a candidate for re-direction to an alternate setting after 1-2 infusions (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

**Diagnosis related to use:**

☐ ankylosing spondylitis (AS)
☐ chronic plaque psoriasis (CPP)
☐ psoriatic arthritis (PsA)
☐ other (Please specify):
☐ non-radiographic axial spondyloarthritis (nr-axSpA)
☐ Crohn's disease
☐ rheumatoid arthritis (RA)

(if CPP or PsA) Does your patient have a dual diagnosis of chronic plaque psoriasis (CPP) AND psoriatic arthritis (PsA)?
☐ Yes ☐ No, only CPP ☐ No, only PsA

**Clinical Information:**

**ankylosing spondylitis (AS):**

(if AS) Is this drug being prescribed by, or in consultation with, a rheumatologist or prescriber who specializes in ankylosing spondylitis? ☐ Yes ☐ No
Has the patient already received a biologic for their condition? ☐ Yes ☐ No
(if AS) Did your patient try one non-steroidal anti-inflammatory drug (NSAID), but it either did not work well enough OR caused a significant intolerance? ☐ Yes ☐ No

(if no) Is your patient able to try the alternative, one NSAID?

(if no) What is the reason your patient can not try the alternative, one NSAID?
☐ Patient has at least one contraindication or warning as listed in the alternative drug's prescribing information.
☐ Patient is not a candidate for the alternative due to a disease characteristic, individual clinical factor[s], or other attribute/condition.
☐ other
Please provide specifics to support this reason.

What alternatives have been tried? Please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. _____

(if AS) Based on the list of drugs tried before, has your patient received any of the following:
A. Enbrel,
B. Humira,
C. Taltz?
☐ Yes to 1 alternative
☐ Yes to 2 or more alternatives
☐ No

(if yes to 1 alt) Based on the information provided, did the tried drug either not work well enough OR cause a significant intolerance? ☐ Yes ☐ No

(if yes to 2 or more alts) Based on the information provided, did the tried drugs either not work well enough OR cause a significant intolerance? ☐ Yes ☐ No

(if no or only tried 1 or less alts) For all drugs NOT tried above (see note), is your patient able to try those drugs?

(if no) What is the reason your patient can not try those drugs?
☐ Patient has at least one contraindication or warning as listed in the alternative drug's prescribing information.
☐ Patient is unable to take those drugs and requires the dosage formulation of the requested drug.
☐ Patient is not a candidate for the alternative due to a disease characteristic, individual clinical factor[s], or other attribute/condition.
☐ other

Please provide specifics to support this reason.

**if non-radiographic axial spondyloarthritis (nr-axSpA):**
(if nr-axSpA) Is this drug being prescribed by, or in consultation with, a rheumatologist or a prescriber who specializes in non-radiographic axial spondyloarthritis (nr-axSpA)? ☐ Yes ☐ No
(if nr-axSpA) Did/Does your patient have objective signs of inflammation, defined as ONE of the following?
☐ C-reactive protein (CRP) elevated beyond the upper limit of normal for the reporting laboratory
☐ sacroiliitis reported on magnetic resonance imaging (MRI)
☐ neither of the above/unknown

**Crohn's disease:**
Is this drug being prescribed by, or in consultation with, a gastroenterologist or a prescriber who specializes in Crohn's disease?
☐ Yes ☐ No
Did your patient try Humira, but it either did not work well enough OR caused a significant intolerance? ☐ Yes ☐ No
(if no) Is your patient able to try the alternative, Humira?
(if no) What is the reason your patient can not try the alternative, Humira?
☐ Patient has at least one contraindication or warning as listed in the alternative drug's prescribing information.
☐ Patient is unable to take those drugs and requires the dosage formulation of the requested drug.
☐ Patient is not a candidate for the alternative due to a disease characteristic, individual clinical factor[s], or other attribute/condition.
☐ other
Please provide specifics to support this reason.

**chronic plaque psoriasis (CPP):**
(if CPP) Is this drug being prescribed by, or in consultation with, a dermatologist or a prescriber who specializes in plaque psoriasis?
☐ Yes ☐ No

Which of the following applies to your patient's disease?
☐ affected BSA (body surface area) is greater than 5%
☐ affected BSA is less than 5% AND there is involvement of the scalp, face, the palms and soles (palmoplantar disease), or genitals
☐ neither of the above

Has the patient already received a biologic for their condition? ☐ Yes ☐ No
(if CPP) Did your patient try Systemic therapy (for example, methotrexate, cyclosporine, Soriatane), but it either did not work well enough OR caused a significant intolerance? ☐ Yes ☐ No
(if no) Is your patient able to try the alternative, Systemic therapy (for example, methotrexate, cyclosporine, Soriatane)?
☐ Yes ☐ No
(if no) What is the reason your patient can not try the alternative, Systemic therapy (for example, methotrexate, cyclosporine, Soriatane)?
☐ Patient has at least one contraindication or warning as listed in the alternative drug's prescribing information.
☐ Patient is not a candidate for the alternative due to a disease characteristic, individual clinical factor[s], or other attribute/condition.
☐ other
Please provide specifics to support this reason.

(if CPP) Did your patient try Phototherapy [narrow or broad band ultraviolet B (UVB), or psoralen plus ultraviolet A (PUVA)], but it either did not work well enough OR caused a significant intolerance? ☐ Yes ☐ No
(if no) Is your patient able to try the alternative, Phototherapy [narrow or broad band ultraviolet B (UVB), or psoralen plus ultraviolet A (PUVA)]? ☐ Yes ☐ No
(if no) What is the reason your patient can not try the alternative, Phototherapy [narrow or broad band ultraviolet B (UVB), or psoralen plus ultraviolet A (PUVA)]?
☐ Patient has at least one contraindication or warning as listed in the alternative drug's prescribing information.
☐ Patient is not a candidate for the alternative due to a disease characteristic, individual clinical factor[s], or other attribute/condition.
☐ other
Please provide specifics to support this reason.

(if CPP) Did your patient try Topical therapy (for example, coal tar, keratolytics, corticosteroids, anthralin, Dovonex, Tazorac)], but it either did not work well enough OR caused a significant intolerance? ☐ Yes ☐ No
(if no) Is your patient able to try the alternative, Topical therapy (for example, coal tar, keratolytics, corticosteroids, anthralin, Dovonex, Tazorac)]? ☐ Yes ☐ No
(if no) What is the reason your patient can not try the alternative, Topical therapy (for example, coal tar, keratolytics, corticosteroids, anthralin, Dovonex, Tazorac)]?
☐ Patient has at least one contraindication or warning as listed in the alternative drug's prescribing information.
☐ Patient is not a candidate for the alternative due to a disease characteristic, individual clinical factor[s], or other attribute/condition.

☐ other

Please provide specifics to support this reason.

(if CPP) Based on the list of drugs tried before, has your patient received any of the following:
1. Enbrel,
2. Humira,
3. Otezla,
4. Skyrizi,
5. Stelara (subcutaneous),
6. Taltz,
7. Tremfya?

☐ Yes to 1 alternative
☐ Yes to 2 or more alternatives
☐ No

(if yes to 1 alt) Based on the information provided, did the tried drug either not work well enough OR cause a significant intolerance? ☐ Yes ☐ No

(if yes to 2 or more alts) Based on the information provided, did the tried drugs either not work well enough OR cause a significant intolerance? ☐ Yes ☐ No

(if no or only tried 1 or less alts) For all drugs NOT tried above (see note), is your patient able to try those drugs? ☐ Yes ☐ No

(if no) What is the reason your patient can not try those drugs?

☐ Patient has at least one contraindication or warning as listed in the alternative drug's prescribing information.
☐ Patient is unable to take those drugs and requires the dosage formulation of the requested drug.
☐ Patient is not a candidate for those drugs due to a disease characteristic, individual clinical factor[s], or other attribute/condition.
☐ other

Please provide specifics to support this reason.

**if psoriatic arthritis (PsA):**

(if PsA) Is this drug being prescribed by, or in consultation with, a rheumatologist, dermatologist or a prescriber who specializes in psoriatic arthritis? ☐ Yes ☐ No

Has the patient already received a biologic for their condition? ☐ Yes ☐ No

Did your patient try one disease-modifying anti-rheumatic drug (DMARD) (for example, methotrexate, leflunomide, sulfasalazine), but it either did not work well enough OR caused a significant intolerance? ☐ Yes ☐ No

(if no) Is your patient able to try the alternative, one DMARD? ☐ Yes ☐ No

(if no) What is the reason your patient can not try the alternative, one DMARD?

☐ Patient has at least one contraindication or warning as listed in the alternative drug's prescribing information.
☐ Patient is not a candidate for the alternative due to a disease characteristic, individual clinical factor[s], or other attribute/condition.
☐ other

Please provide specifics to support this reason.

Based on the list of drugs tried before, has your patient received any of the following:
1. Enbrel,
2. Humira,
3. Otezla,
4. Stelara (subcutaneous),
5. Taltz,
6. Tremfya,
7. Xeljanz/Xeljanz XR?

☐ Yes to 1 alternative
☐ Yes to 2 or more alternatives
☐ No

(if yes to 1 alt) Based on the information provided, did the tried drug either not work well enough OR cause a significant intolerance? ☐ Yes ☐ No

(if yes to 2 or more alts) Based on the information provided, did the tried drugs either not work well enough OR cause a significant intolerance? ☐ Yes ☐ No

(if no or only tried 1 or less alts) For all drugs NOT tried above (see note), is your patient able to try those drugs? ☐ Yes ☐ No

(if no) What is the reason your patient can not try those drugs?

☐ Patient has at least one contraindication or warning as listed in the alternative drug's prescribing information.
☐ Patient is unable to take those drugs and requires the dosage formulation of the requested drug.
☐ Patient is not a candidate for those drugs due to a disease characteristic, individual clinical factor[s], or other attribute/condition.
☐ other

Please provide specifics to support this reason.

**if rheumatoid arthritis(RA):**
Is this drug being prescribed by, or in consultation with, a rheumatologist or a prescriber who specializes in rheumatoid arthritis? ☐ Yes ☐ No
Has the patient already received a biologic for their condition? ☐ Yes ☐ No
Did your patient try one disease-modifying anti-rheumatic drug (DMARD) (for example, methotrexate, leflunomide, sulfasalazine), but it either did not work well enough OR caused a significant intolerance? ☐ Yes ☐ No
(if no) Is your patient able to try the alternative, one DMARD? ☐ Yes ☐ No
(if no) What is the reason your patient can not try the alternative, one DMARD?
☐ Patient has at least one contraindication or warning as listed in the alternative drug's prescribing information.
☐ Patient is not a candidate for the alternative due to a disease characteristic, individual clinical factor[s], or other attribute/condition.
☐ other
Please provide specifics to support this reason.

Based on the list of drugs tried before, has your patient received any of the following:
1. Actemra (subcutaneous),
2. Enbrel,
3. Humira,
4. Rinvoq,
5. Xeljanz/Xeljanz XR?

☐ Yes to 1 alternative
☐ Yes to 2 or more alternatives
☐ No

(if yes to 1 alt) Based on the information provided, did the tried drug either not work well enough OR cause a significant intolerance? ☐ Yes ☐ No
(if yes to 2 or more alts) Based on the information provided, did the tried drugs either not work well enough OR cause a significant intolerance? ☐ Yes ☐ No
(if no or only tried 1 or less alts) For all drugs NOT tried above (see note), is your patient able to try those drugs? ☐ Yes ☐ No
(if no) What is the reason your patient can not try those drugs?
☐ Patient has at least one contraindication or warning as listed in the alternative drug's prescribing information.
☐ Patient is unable to take those drugs and requires the dosage formulation of the requested drug.
☐ Patient is not a candidate for those drugs due to a disease characteristic, individual clinical factor[s], or other attribute/condition.
☐ other
Please provide specifics to support this reason.

**Additional pertinent information:** *Please include any alternatives tried, with drug name, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced.*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature:**_____ **Date:**_____

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