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 with the requested medication? If your patient has been taking samples, please choose "new start".

☐ new start ☐ continuation of therapy

If continuation of therapy:
Has your patient demonstrated a beneficial response to this medication? ☐ Yes ☐ No
(if no) Please provide clinical support for the continued use of the requested medication:

Besides the drug being requested, other biologics and tsDMARDs (targeted synthetic disease-modifying antirheumatic drugs) include Actemra, adalimumab (Humira and all biosimilars), Adbry, Bimzelx, Cibinqo, Cimzia, Cosentyx, Enbrel, Entyvio, Ilumya, infliximab (Remicade and all biosimilars), Kevzara, Kineret, Litfulo, Olumiant, Omvoh, Orencia, Otezla, Rinvoq, rituximab (Rituxan and all biosimilars), Siliq, Simponi Aria, Simponi, Skyrizi, Sotyktu, Stelara, Taltz, Tremfya, Tysabri, Velsipity, Xeljanz, Zeposia. 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. The requested medication is the only biological the patient is/will be using.
☐ The patient is currently on another biological, but this one will be stopped and the requested medication will be started.
☐ The patient is currently on another biological, and he requested medication will be added. The patient may continue to take both medications together.
☐ The patient is currently on BOTH the requested medication AND another biological.
☐ other

(if other/more than the requested medication) Please provide rationale for concurrent use.

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 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):

Where will this drug be administered?

☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

NOTE: *Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options 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)
☐ non-radiographic axial spondyloarthritis (nr-axSpA)
☐ Crohn's disease
☐ rheumatoid arthritis (RA)
☐ Spondyloarthritis (non-axial disease): reactive arthritis (Reiter's disease) and undifferentiated arthritis
☐ other (Please specify):

Clinical Information:

(if AS, Crohn's [18 yrs or older], CPP, PsA, or RA) Is there documentation that your patient either has had failure (didn't work) or did not tolerate any of the following? (Check all that apply):

☐ Actemra SC
☐ Adalimumab-adaz
☐ Adalimumab-adbm
☐ Cosentyx
☐ Cyltezo
☐ Enbrel
☐ Hadlima
☐ Humira
☐ Hyrimoz (by Sandoz/Novartis)
☐ Otezla
☐ Rinvoq
☐ Skyrizi SC
☐ Stelara SC
☐ Taltz
☐ Tremfya
☐ Xeljanz
☐ Xeljanz XR
☐ Other

Please provide drug name(s), date(s) taken and what the documented results were for each drug tried:

(if AS, Crohn's [18 yrs or older], CPP, PsA, or RA) Is there documentation that your patient has a contraindication to any of the following? (Check all that apply):

☐ Actemra SC
☐ Adalimumab-adaz
☐ Adalimumab-adbm
☐ Cosentyx
☐ Cyltezo
☐ Enbrel
☐ Hadlima
☐ Humira
☐ Hyrimoz (by Sandoz/Novartis)
☐ Otezla
☐ Rinvoq
☐ Skyrizi SC
☐ Stelara SC
☐ Taltz
☐ Tremfya
☐ Xeljanz
☐ Xeljanz XR
☐ Other

Please provide the drug name(s) and details why they can't try that alternative [including contraindications according to the FDA label; warnings per the prescribing information (labeling); disease characteristic or clinical factor the patient has].

ankylosing spondylitis (AS):

(if AS) Is this medication being prescribed by, or in consultation with, a rheumatologist? ☐ Yes ☐ No

Has the patient already received a biologic or targeted synthetic DMARD (tsDMARD) for their condition? ☐ Yes ☐ No

(if AS) The covered alternative is one non-steroidal anti-inflammatory drug (NSAID). If your patient has tried this medication, please provide name, strength, date(s) taken and for how long, and what the documented results were of taking this medication, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this medication, please provide details why your patient can't try this alternative. Notes: Examples of NSAIDs: diclofenac (Cataflam, Voltaren, Voltaren XR), diflunisal (Dolobid), etodolac (Lodine), etodolac ER, fenoprofen (Nalfon), flurbiprofen (Ansaid), ibuprofen (Motrin), indomethacin (Indocin), indomethacin ER, ketoprofen, meclofenamate, mefenamic acid (Ponstel), meloxicam (Mobic), nabumetone (Relafen), naproxen (Naprosyn), naproxen sodium (Anaprox, Anaprox DS), oxaprozin (Daypro), piroxicam (Feldene), sulindac (Clinoril), or tolmetin (Tolectin).

(if AS) Per the information provided above, which of the following is true for your patient in regard to the covered alternative?
☐ The patient tried the alternative, but it didn't work.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this medication.
☐ Other

if non-radiographic axial spondyloarthritis (nr-axSpA):
(if nr-axSpA) Is this medication being prescribed by, or in consultation with, a rheumatologist? ☐ 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

(for nr-axSpA) Has the patient already received a biologic or targeted synthetic DMARD (tsDMARD) for their condition?
☐ Yes ☐ No

(if nr-axSpA) The covered alternative is one non-steroidal anti-inflammatory drug (NSAID). If your patient has tried this medication, please provide name, strength, date(s) taken and for how long, and what the documented results were of taking this medication, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this medication, please provide details why your patient can't try this alternative.

(if nr-axSpA) Per the information provided above, which of the following is true for your patient in regard to the covered alternative?
☐ The patient tried the alternative, but it didn't work.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to it.
☐ Other

Crohn's disease:

Is this medication being prescribed by, or in consultation with, a gastroenterologist? ☐ Yes ☐ No

(if CD) Has the patient already received a biologic for their condition? ☐ Yes ☐ No

(if CD) Does the patient meet ONE of these? Check all that apply.
☐ Severe disease needing hospitalization
☐ Involvement of the UPPER GI tract
☐ Patient is a Smoker
☐ Patient is LESS THAN 40 years of age
☐ Stricturing disease
☐ Perianal disease
☐ Other enterocutaneous fistula
☐ Extraintestinal manifestations (ankylosing spondylitis, pyoderma gangrenosum, erythema nodosum)
☐ Previous Crohn's disease-related surgery (for example, ileocolonic resection (to reduce the chance of Crohn's disease recurrence)
☐ Bowel obstruction
☐ History of abscess or perforation (after healing)
☐ None of the above

(if CD) The covered alternative is one corticosteroid, or a corticosteroid will be taken concurrently with this medication. If your patient has tried this medication, please provide name, strength, date(s) taken and for how long, and what the documented results were of taking this medication, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this medication, please provide details why your patient can't try this alternative.

(if CD) Per the information provided above, which of the following is true for your patient in regard to the covered alternative?
☐ The patient tried the alternative, but it didn't work.
☐ The patient will take a corticosteroid concurrently with the requested medication.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to it.
☐ Other

(if CD) The covered alternative is one other conventional systemic therapy, or a conventional systemic therapy will be taken concurrently with this medication. If your patient has tried this medication, please provide name, strength, date(s) taken and for how long, and what the documented results were of taking this medication, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this medication, please provide details why your patient can't try this alternative.

(if CD) Per the information provided above, which of the following is true for your patient in regard to the covered alternative?
☐ The patient tried the alternative, but it didn't work.
☐ The patient will take a conventional systemic therapy concurrently with the requested medication
☐ The patient tried ALL other conventional systemic therapies, but they did not tolerate them.
☐ The patient cannot try ANY other conventional systemic therapies because of a contraindication to each.
☐ Other

chronic plaque psoriasis (CPP):
(if CPP) Is this medication being prescribed by, or in consultation with, a dermatologist? ☐ 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 or targeted synthetic DMARD (tsDMARD) for their condition? ☐ Yes ☐ No

(if Plaque Psoriasis) The covered alternatives are: A. Topical therapy (for example, topical corticosteroids, topical vitamin D analogs, Tazorac); B. Systemic therapy (for example, methotrexate, cyclosporine, Soriatane); C. Phototherapy. For the alternatives tried, please include name and strength, date(s) taken and for how long, and what the documented results were of taking each therapy, including any intolerances or adverse reactions your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try that therapy.

(if Plaque Psoriasis) Per the information provided above, which of the following is true for your patient in regard to the covered alternatives?
☐ The patient tried one of the alternatives, but it didn't work.
☐ The patient tried ALL of the alternatives, but they did not tolerate ANY of them.
☐ The patient cannot try ANY of these alternatives because of a contraindication to ALL of the alternatives.
☐ Other

if psoriatic arthritis (PsA):
(if PsA) Is this medication being prescribed by, or in consultation with, a rheumatologist, or dermatologist? ☐ Yes ☐ No

if rheumatoid arthritis(RA):

Is this medication being prescribed by, or in consultation with, a rheumatologist? ☐ Yes ☐ No

Has the patient already received a biologic or targeted synthetic DMARD (tsDMARD) for their condition? ☐ Yes ☐ No

(if RA) The covered alternative is one conventional synthetic disease-modifying anti-rheumatic drug (csDMARD). If your patient has tried this medication, please provide name, strength, date(s) taken and for how long, and what the documented results were of taking this medication, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this medication, please provide details why your patient can't try this alternative.

(if RA) Per the information provided above, which of the following is true for your patient in regard to the covered alternative?

☐ The patient tried one of the alternatives, but it didn't work.
☐ The patient tried ALL csDMARDs, but they did not tolerate any of them.
☐ The patient cannot try ANY csDMARDs because of a contraindication to each of these drugs..
☐ Other

If Spondyloarthritis (non-axial disease): reactive arthritis (Reiter's disease) and undifferentiated arthritis:

(if Spondyloarthritis) Has the patient already received a biologic for non-axial spondyloarthritis? ☐ Yes ☐ No

(if Spondyloarthritis) The covered alternative is one conventional synthetic disease-modifying anti-rheumatic drug (csDMARD). If your patient has tried this medication, please provide name, strength, date(s) taken and for how long, and what the documented results were of taking this medication, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this medication, please provide details why your patient can't try this alternative.

(if Spondyloarthritis) Per the information provided above, which of the following is true for your patient in regard to the covered alternative?

☐ The patient tried the alternative, but it didn't work.
☐ The patient tried ALL csDMARDs, but they did not tolerate them.
☐ The patient cannot try ANY csDMARDs because of a contraindication to each.
☐ Other

(if Spondyloarthritis) Does the patient have arthritis primarily in the knees, ankles, elbows, wrists, hands, and/or feet? ☐ Yes ☐ No

(if Spondyloarthritis) Is this medication being prescribed by, or in consultation with, a rheumatologist? ☐ Yes ☐ No

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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