MEDICARE FORM

Cimzia® (certolizumab pegol) Injectable Medication Precertification Request

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

For Medicare Advantage Part B:
For other lines of business:
Please use commercial form.

Note: Cimzia is non-preferred. Preferred products vary based on indication. See section G below.

Would you like to use electronic prior authorization? Consider using **Availity**, our electronic prior authorization portal. Learn more about **Availity** from the links in the table below.

For phone or fax requests, refer to the table below for routing information. To determine which box to use, refer to the patient's Aetna ID card. State specific special needs and Medicare-Medicaid Plans may be designated on the front of the ID card or in the website URL on the back of the card. If you don't see your specific plan listed, call the number on the back of the member's ID card to confirm routing information.

For **Aetna Medicare Advantage** and **Allina Health Aetna Medicare** members send request to: **Phone:** 1-866-503-0857 **(TTY:** 711**)** **Fax:** 1-844-268-7263 **Availity:** https://www.aetna.com/health-care-professionals/resource-center/availity.html
For Aetna Medicare Advantage **Virginia Dual Eligible Special Needs Plans** (HMO D-SNP) send request to: **Phone:** 1-855-463-0933 **Fax:** 1-833-280-5224 **Availity:** https://www.aetnabetterhealth.com/virginia-hmosnp/providers/portal
For Aetna Assure Premier Plus Medicare Advantage **New Jersey Dual Eligible Special Needs Plans** (HMO D-SNP) send request to: **Phone:** 1-844-362-0934 **Fax:** 1-833-322-0034 **Availity:** https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/portal.html
For Aetna Better Health of **Illinois Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-866-600-2139 **FAX:** 1-855-320-8445 **Availity:** https://www.aetnabetterhealth.com/illinois/providers/portal
For Aetna Better Health of **Ohio Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-855-364-0974 **Fax:** 1-855-734-9389 **Availity:** https://www.aetnabetterhealth.com/ohio/providers/portal
For Aetna Better Health of **Michigan Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-855-676-5772 **Fax:** 1-844-241-2495 **Availity:** https://www.aetnabetterhealth.com/michigan/providers/portal.html

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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** ☐ Dermatologist ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office ☐ Home
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

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

E. PRODUCT INFORMATION

Request is for: ☐ **Cimzia (certolizumab pegol)** **HCPCS Code:** _____

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):

What is the patient's diagnosis?
☐ Moderately to severely active Crohn's disease ☐ Moderately to severely active rheumatoid arthritis ☐ Psoriatic arthritis
☐ Ankylosing spondylitis ☐ Non-radiographic axial spondyloarthritis ☐ Polyarticular juvenile idiopathic arthritis ☐ Moderate to severe plaque psoriasis
☐ Immune checkpoint inhibitor-related toxicity – inflammatory arthritis ☐ Other

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

Note: Cimzia is non-preferred. Entyvio IV, Inflectra, Renflexis, Simponi Aria and Tremfya IV are preferred for MA plans. For MAPD plans, Cosentyx SC, Enbrel, Humira, Idacio, Rinvoq, Skyrizi, Sotyktu, Stelara, Tremfya, Tyenne SC 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?
☐ No Has the patient had a trial and failure of any of the following? (if yes, select all that apply below)
☐ Entyvio IV (vedolizumab) ☐ Inflectra (infliximab-dyyb) ☐ Renflexis (infliximab-abda)
☐ Simponi Aria (golimumab) ☐ Tremfya IV (guselkumab)
→ When was the member's trial and failure of the preferred drug? _____
→ Please describe the nature of the failure of the preferred drug _____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

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

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

☐ No Has the patient had an adverse reaction to any of the following? (if yes, select all that apply below)
- ☐ Entyvio IV (vedolizumab) ☐ Inflectra (infliximab-dyyb) ☐ Renflexis (infliximab-abda)
- ☐ Simponi Aria (golimumab) ☐ Tremfya IV (guselkumab)
- → When was the member's adverse reaction to the preferred drug? _____
- → Please describe the nature of the adverse reaction to the preferred drug _____

☐ No Has the patient had a trial and failure of any of the following? (if yes, select all that apply below)
- ☐ Cosentyx SC (secukinumab) ☐ Enbrel (etanercept) ☐ Humira (adalimumab) ☐ Idacio (adalimumab-aacf) ☐ Rinvoq (upadacitinib)
- ☐ Skyrizi (risankizumab-rzaa) ☐ Sotyktu (deucravacitinib) ☐ Stelara (ustekinumab) ☐ Tremfya (guselkumab)
- ☐ Tyenne SC (tocilizumab-aazg) ☐ Xeljanz/Xeljanz XR (tofacitinib)
- → When was the member's trial and failure of the preferred drug? _____
- → Please describe the nature of the failure of the preferred drug _____

☐ No Has the patient had an adverse reaction to any of the following? (if yes, select all that apply below)
- ☐ Cosentyx SC (secukinumab) ☐ Enbrel (etanercept) ☐ Humira (adalimumab) ☐ Idacio (adalimumab-aacf) ☐ Rinvoq (upadacitinib)
- ☐ Skyrizi (risankizumab-rzaa) ☐ Sotyktu (deucravacitinib) ☐ Stelara (ustekinumab) ☐ Tremfya (guselkumab)
- ☐ Tyenne SC (tocilizumab-aazg) ☐ Xeljanz/Xeljanz XR (tofacitinib)
- → When was the member's adverse reaction to the preferred drug? _____
- → Please describe the nature of the adverse reaction to the preferred drug _____

Please explain if there are any contraindications or 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 IV (vedolizumab) ☐ Inflectra (infliximab-dyyb) ☐ Renflexis (infliximab-abda) ☐ Simponi Aria (golimumab) ☐ Tremfya IV (guselkumab)

_____

Please explain if there are any contraindications or 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)

☐ Cosentyx SC (secukinumab) ☐ Enbrel (etanercept) ☐ Humira (adalimumab) ☐ Idacio (adalimumab-aacf) ☐ Rinvoq (upadacitinib)
☐ Skyrizi (risankizumab-rzaa) ☐ Sotyktu (deucravacitinib) ☐ Stelara (ustekinumab) ☐ Tremfya (guselkumab)
☐ Tyenne SC (tocilizumab-aazg) ☐ Xeljanz/Xeljanz XR (tofacitinib)

_____

☐ Crohn's disease:
- ☐ Yes ☐ No Has the patient been diagnosed with moderately to severely active Crohn's disease?

☐ Rheumatoid arthritis:
- ☐ Yes ☐ No Has the patient been diagnosed with moderately to severely active rheumatoid arthritis?

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

☐ Ankylosing spondylitis:
- ☐ Yes ☐ No Has the patient been diagnosed with active ankylosing spondylitis?

☐ Non-radiographic axial spondyloarthritis:
- ☐ Yes ☐ No Has the patient been diagnosed with active non-radiographic axial spondyloarthritis?

☐ Polyarticular juvenile idiopathic arthritis:
- ☐ Yes ☐ No Has the patient been diagnosed with active polyarticular juvenile idiopathic arthritis?

☐ Plaque psoriasis:
- ☐ Yes ☐ No Has the patient been diagnosed with active moderate to severe plaque psoriasis?

☐ For immune checkpoint inhibitor-related toxicity
- ☐ Yes ☐ No Has the patient been diagnosed with severe immunotherapy-related inflammatory arthritis?

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

☐ Yes ☐ No Is the patient receiving benefit from therapy with the requested drug?

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.