	Page 1 of 3	completed and legible for	•	eview.) For		vantage Part B:		
Please indicate: Start				Plea	ase Use Medic	care Request Form		
	inuation of therapy: Date o	f last treatment /			_			
Precertification Request			Phon	e:	Fax:			
A. PATIENT INFORMATION								
First Name:		Last Name:			DOB:			
Address:		City:			State:	ZIP:		
Home Phone:	Work Phone:		Cell Phone:		Email:			
	lbs_orkgs_Pati	ient Height: inches	s or <u> </u>	a Allergies:				
B. INSURANCE INFORMAT								
Aetna Member ID #:		Does patient have othe						
Group #: Insured:		If yes, provide ID#: Insured:						
	If yoo provide ID #:				ida ID #i			
Medicare: Yes No C. PRESCRIBER INFORMA		Wet		□ No If yes, prov	ide ID #.			
First Name:	TION	Last Name:		(Check One). ПМР Г] D.O. 🗌 N.P. 🗌 P.A.		
Address:		City:		(encon enc)	State:	ZIP:		
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	olulo.	UPIN:		
Provider Email:		Office Contact Name:		DER.	Phone:	or it.		
					T Hone.			
,	Gastroenterologist 🗌 Rhe	-		er:				
D. DISPENSING PROVIDE: Place of Administration:	R/ADMINISTRATION INFORM	MATION	Diananaing	Provider/Pharmac	W. Detient Se	lastad abaiaa		
	Physician's Office			n's Office	-			
	iter Phone:			Pharmacy		-		
-								
	Phone:		Name:					
Agency Name:								
Administration code(s)	•		TIN:		PIN:			
E. PRODUCT INFORMATIC			_					
	rtolizumab pegol) Dose:							
	ON - Please indicate primary							
-		-						
	N - Required clinical informati		ALL precertificat	ion requests.				
	ocumentation required for a							
	uested drug be used in combir ent ever received (including c							
with an incr	eased risk of tuberculosis?	, 0		0 ,				
$\hookrightarrow \Box$ Yes \Box	No Has the patient had a tub within 6 months of initiati		uberculosis skin t	test [PPD], interferon	-release assay	[IGRA], chest x-ray)		
		• • • •	amma assav (IG	RA) ∏ chest x-rav				
Check all that apply): PPD test interferon-gamma assay (IGRA) check that apply check all that apply): PPD test interferon-gamma assay (IGRA) check that apply check and the provided that apply check and the p								
If positive, please indicate which applies to the patient:								
☐ latent TB and treatment for latent TB has been initiated								
☐ latent TB and treatment for latent TB has been completed ☐ latent TB and treatment for latent TB has not been initiated								
\Box active TB								
For Initiation Requests (clinical documentation required for all requests):								
Ankylosing spondylitis an	d axial spondyloarthritis							
	se at weeks 0, 2 and 4:							
	ollowing applies to the patient			Active axial spondyl	oarthritis			
Yes No Is the requested drug being prescribed by or in consultation with a rheumatologist?								
Yes No Is the patient female and currently pregnant or breastfeeding?								
Yes No Has the patient had an ineffective response, contraindication, or intolerance to Avsola or Inflectra (one-month trial)?								
Yes No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) that is								
indicated for active ankylosing spondylitis or active axial spondyloarthritis?								
does the patient have an intolerance or contraindication to at least two NSAIDs?								

Continued on next page

Cimzia® (certolizumab pegol) Injectable Medication Precertification Request

Aetna Precertification Notification Phone: <u>1-866-752-7021</u> (TTY: <u>711</u>) FAX: <u>1-888-267-3277</u>



Cimzia[®] (certolizumab pegol) Injectable Medication Precertification Request

Page 2 of 3

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

Aetna Precertification Notification Phone: <u>1-866-752-7021</u> (TTY: <u>711</u>) FAX: <u>1-888-267-3277</u>

For Medicare Advantage Part B: Please Use Medicare Request Form

	Patient First Name	Patient Last Name	Patient Phone	Patient DOB				
Croin disease Presse indicate loading dose at weeks 0, 2, and 4 Please indicate maintenance dose: frequency: weeks Presse indicate loading dose at weeks 0, 2, and 4 Please indicate maintenance dose: frequency: weeks Presse indicate in the requested drug being prescribed by or in consultation with a gaterian indicate for moterial therapy option? weeks Presse indicate in the requested drug being prescribed in the analysis of the a	G. CLINICAL INFORMATION (contin	<i>ued</i>) – Required clinical information must be co	mpleted in its entirety for all precerti	fication requests.				
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Please indicates indicates or intolerance to at lease one conventional therapy option (e.g., azathoprine (Parinethol), methylprednisolone (Solu-Medrol), methylprednisolone (Solu-Medrol), methylprednisolone (Solu-Medrol), methylprednisolone (Solu-Medrol), methylprednisolone (Solu-Medrol), methylprednisolone (Solu-Medrol) Please select: [] Sulfasalazine (Azatifane, Sulfazine) [] Methylprednisolone (Solu-Medrol) Please select: [] Sulfasalazine (Azatifane, Sulfazine) [] Methylprednisolone (Solu-Medrol) Please indicate loading dose at weeks 0.2 and 4								
<pre>azathioprine [Azasan, Imuran], budesonide [Entocott EC], ciproloxacin (Cipro], mercaptopurine [Purinethol],</pre>								
<pre>// Azulfidine, Sulfazine], rifaximin j/fitaxani, lacrolimus)? // Please select: // Sulfazine], rifaximin j/fitaxani, lacrolimus)? // Ciprofloxacin (Cipro) Prednisone Budesonide (Entocot EC) Azathioprine (Azasan, Imuran) Rifaximin (Xifaxan)Tarcolimus Plaque psoriasis Plaque psoriasis Plase indicate loading dose at weeks 0.2 and 4: Please indicate maintenance dose: frequency: weeks // See No. Has the patient been diagnosed with moderate to severe plaque psoriasis? // See No. Is the requested drug being prescribed by or in consultation with a dematologist? // See No. Is the patient female and currently pregnant or breastfeeding? // See No. Is the patient due an ineffective response, contraindication, or intolerance to lumya (one-month trial)? // See No. Has the patient had an ineffective response, contraindication, or intolerance to Avoida or Inflectra (one-month trial)? // See No. Has the patient had an ineffective response, contraindication, or intolerance to Avoida or Inflectra (one-month trial)? // See No. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? // See No. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? // See No. Are strucial body areas (e.g., nands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? // See Please indicate locial reason to avoid pharmacologic treatment with methortexate, cyclosporine or a activation? // See No. Has the patient experienced an inadequate response, or has an intolerance to boltotherapy (e.g., UVB, PUVA) or // Pharmacologic treatment with methortexate, cyclosporine or a activation? // Please indicate locial dignosis of alcohol use disorder, alcoholic liver disease or other chonic liver disease // See</pre>		azathioprine [Azasan, Imuran], bude	esonide [Entocort EC], ciprofloxacin	[Cipro], mercaptopurine [Purinethol],				
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\square Yes \square No Does the patient have a contraindication to methotrexate or leftunomide?								
└───> ☐ Yes ☐ No Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasalazine)?		\hookrightarrow L						

Continued on next page

Cimzia[®] (certolizumab pegol) Injectable Medication Precertification Request

Page 3 of 3

♥aetna

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

Aetna Precertification Notification Phone: <u>1-866-752-7021</u> (TTY: <u>711</u>) FAX: <u>1-888-267-3277</u>

For Medicare Advantage Part B: Please Use Medicare Request Form

Patient First Name	Patient Last Name	Patient Phone	Patient DOB					
	<i>ued)</i> – Required clinical information must be con							
	If yes, please indicate the contraindication: History of intolerance or adverse event Renal impairment Hypersensitivity Myelodysplasia Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia) Breastfeeding Elevated liver transaminases Interstitial pneumonitis or							
	Pregnancy or currently planning pregnancy							
disorder, alcoholic liver disease or othe			-					
Rheumatoid arthritis								
	0, 2 and 4: Please indicate maintenan		weeks					
	diagnosed with moderately to severely active rhe being prescribed by or in consultation with a rhe							
	and currently pregnant or breastfeeding?							
	he patient had an ineffective response, contraine	dication, or intolerance to Simponi A	Aria (one-month trial)?					
	he patient had an ineffective response, contraine							
	eceived (including current utilizers) a biologic (e. erely active rheumatoid arthritis?	g., Humira) or targeted synthetic d	ug (e.g., Rinvoq, Xeljanz) indicated					
└─── ── Yes □ No Does	the patient meet either of the following: a) the patient	atient was tested for the rheumatoi	l factor (RF) biomarker and the					
	omarker test was positive, or b) the patient was nti-CCP biomarker test was positive?	tested for the anti-cyclic citrullinate	d peptide (anti-CCP) biomarker and					
	\square No Has the patient been tested for all of	the following biomarkers: a) rheum	atoid factor (RF) b) anti-cyclic					
			erythrocyte sedimentation rate (ESR)?					
	he patient experienced an inadequate response or equal to 15 mg per week?	after at least 3 months of treatmen	t with methotrexate at a dose greater					
	es 🔲 No Has the patient experienced an intoler							
	└────────────────────────────────────		e?					
	· · · · · · · · · · · · · · · · · · ·	ance or adverse event	npairment					
	_ ;	(e.g., thrombocytopenia, leukopen						
	-] Elevated liver transaminases						
	🗌 Interstitial pneum	onitis or clinically significant pulmo	nary fibrosis					
	Pregnancy or cur	rently planning pregnancy 🛛 Sigi	nificant drug interaction					
		of alcohol use disorder, alcoholic l	iver disease or other chronic					
	liver disease							
For Continuation Paguasts (clinical d	Other: locumentation required for all requests):							
Please indicate maintenance dose:								
	receiving the requested drug through samples of	or a manufacturer's patient assistan	ce program?					
Yes No Has the patient achieve	ed or maintained positive clinical response as ev	videnced by low disease activity or	improvement in signs and symptoms					
0	t with the requested drug?							
Ankylosing spondylitis and axial spo Please indicate which of the following	-							
	bain Inflammation (e.g., morning stiffness)	☐ None of the above						
Crohn's disease								
☐ Yes ☐ No Has the patient achiev	/ed 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								
	scoring tool (e.g., Crohn's Disease Activity Index	([CDAI] score) [] None of the ab	ove					
Plaque psoriasis		ffe stad from has aligned						
_ <u> </u>	ienced a reduction in body surface area (BSA) a he patient experienced an improvement in signs		m haseline (e.g., itching, redness					
· · · ·	g, scaling, burning, cracking, pain)?		n baseline (e.g., itering, redness,					
Psoriatic arthritis								
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 □ Axial disease □ 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.