

**Neighborhood Health Plan of Rhode Island  
Prior Authorization Form  
Cimzia® (Certolizumab Pegol)**

If approval criteria are met, Neighborhood Health Plan of Rhode Island will authorize coverage of Cimzia® (certolizumab pegol). Failure to fill out this form will result in a rejection of this medication at the pharmacy. Thank you for your assistance.

Please complete the following information:

<b>Member Name:</b> (required)	<b>Member ID Number:</b> (required) <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
<b>Member Date of Birth:</b> (required) / /	<b>Member Sex:</b> M      F      (Circle One)										
<b>Prescriber Name:</b> (required)	<b>Contact Person at Office:</b>										
<b>Office Phone number:</b> (required) (    ) -	<b>Office Fax Number:</b> (required) (    ) -										

**\*\*\*Directions of use :**

	YES	NO
1) <b>RHEUMATOID ARTHRITIS:</b> For the treatment of adults with moderately to severely active rheumatoid arthritis (RA)	<input type="checkbox"/>	<input type="checkbox"/>
2) PATIENT HAS HAD AN UNSATISFACTORY RESPONSE TO A PREVIOUS TRIAL OF A DISEASE MODIFYING ANTIRHEUMATIC DRUG (DMARD) OR PREVIOUS TNF THERAPY (I.E. HYDROXYCHLOROQUINE (PLAQUENIL®), AZATHIOPRINE (IMURAN®), SULFASALAZINE (AZULFIDINE®), CYCLOPHOSPHAMIDE (CYTOXAN®), CYCLOSPORINE (NEORAL®), METHOTREXATE), ANAKINRA (KINERET®), ETC PLEASE LIST PRIOR THERAPIES: a) _____ b) _____ c) _____	<input type="checkbox"/>	<input type="checkbox"/>
3)		
4) <b>CROHN DISEASE:</b> For reducing signs and symptoms of Crohn disease and maintaining clinical response in adult patients with moderately to severely active disease who have had an inadequate response to conventional therapy (mesalamine/steroids): PLEASE LIST PRIOR THERAPIES: a) _____ b) _____ c) _____	<input type="checkbox"/>	<input type="checkbox"/>
5) IF THIS IS FOR RENEWAL, HAS PATIENT SHOWN SYMPTOMATIC IMPROVEMENT? PLEASE DESCRIBE: _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
6) IS PATIENT HYPERSENSITIVE TO CIMZIA OR ANY OF ITS COMPONENTS?	<input type="checkbox"/>	<input type="checkbox"/>

**BLACK BOX WARNING**

- Patients treated with certolizumab are at an increased risk for developing serious infections (bacterial, viral, invasive fungal) that may lead to hospitalization or death. Most patients who developed these infections were taking concomitant immunosuppressants such as methotrexate or corticosteroids.
- Patients should be evaluated for latent tuberculosis with a tuberculin skin test prior to Cimzia therapy. Treatment of latent TB should be initiated before Cimzia is used.
- Rare reactivation of hepatitis B has occurred in chronic virus carriers.

**BENEFIT TERMS UPON APPROVAL:**

INITIAL APPROVAL WILL BE FOR 4 MONTHS AT WHICH TIME PATIENT SHOULD BE EVALUATED FOR RESPONSE TO THERAPY. IF PATIENT IS RESPONDING TO THERAPY, AN ADDITIONAL 9 MONTHS WILL BE APPROVED.

**All information provided on this form is accurate as of this date.**

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Directions for Cimzia** \_\_\_\_\_

**Completed forms should be faxed to: Customer Service Department 866-423-0945**