



CIGNA

Pharmacy Services

Phone: (800)244-6224

Fax: (800)390-9745

CIGNA HealthCare Prior Authorization Form - Cimzia (Certolizumab pegol) -

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

PROVIDER INFORMATION			PATIENT INFORMATION		
* Provider 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 or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* CIGNA ID:		
Office Fax:			* Date Of Birth:		
* Is your fax machine kept in a secure location? Yes <input type="checkbox"/> No <input type="checkbox"/>			* Patient Street Address:		
* May we fax our response to your office? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		
Medication requested:					
<input type="checkbox"/> Cimzia (certolizumab pegol) 200mg kit		<input type="checkbox"/> Cimzia (certolizumab pegol) 400mg/2ml syringe kit			
Dose and Quantity:		Duration of therapy:		J-Code:	
Frequency of administration:					
Where will this medication be obtained?					
<input type="checkbox"/> CIGNA Tel-Drug (<i>CIGNA's nationally preferred specialty pharmacy</i>)			<input type="checkbox"/> Retail pharmacy		
<input type="checkbox"/> Prescriber's office stock (billing on a medical claim form)			<input type="checkbox"/> Home Health / Home Infusion vendor		
<input type="checkbox"/> Other (please specify):					
Diagnosis related to use:					
<input type="checkbox"/> Rheumatoid Arthritis					
<input type="checkbox"/> Crohn's Disease					
<input type="checkbox"/> Other (Please specify):					
Chron's Disease:					
Does the patient have a history of positive clinical response to Cimzia (certolizumab pegol) therapy?					
<input type="checkbox"/> Yes		<input type="checkbox"/> No			
Did the patient have a failure, contraindication, or intolerance to conventional therapies (e.g. aminosaliclylate, corticosteroids, or immunomodulators)?					
<input type="checkbox"/> Yes		<input type="checkbox"/> No			
Please indicate if the patient has had evidence of failure, inadequate response, intolerance or contraindication to adalimumab (Humira) or infliximab (Remicade)?					
<input type="checkbox"/> Yes		<input type="checkbox"/> No			

Rheumatoid Arthritis:

Does the patient have a history of positive clinical response to Cimzia (certolizumab pegol) therapy?

- Yes No

Please indicate if the patient has had evidence of failure, inadequate response, intolerance or contraindication to any of the following tumor necrosis factor (TNF) antagonists. Please check all that apply:

- adalimumab (Humira) etanercept (Enbrel) infliximab (Remicade)

Please indicate if the patient has had evidence of failure, inadequate response, intolerance or contraindication to any of the following disease-modifying anti-rheumatic drugs (DMARDs). Please check all that apply:

- Methotrexate Azathioprine Gold Hydroxychloroquine
 Penacillamine Sulfasalazine Other (please specify):

Which of the following methods was used to measure the patient’s disease progression **PRIOR** to therapy on Cimzia? (Check all that apply):

- Health Assessment Questionnaire Disease Index (HAQ-DI) Visual Analogue scale (VAS)
 Likert scales of global response to pain by the patient/doctor Global Arthritis Score (GAS)
 Clinical Disease Activity Index (CDAI) Simplified Disease Activity Index (SDAI)
 Progression of radiographic damage of involved joints Disease Activity Scale (DAS) score
 Disease Activity Score based on 28-joint evaluation (DAS28) score Disease Activity Scale (DAS) score
 Elevation of ESR (> 28 mm/hr), or C-reactive protein (CRP) (2x the upper limit of normal)
 Other (please specify) :

If this is a request for **CONTINUED THERAPY** (after at least 16 weeks of treatment), has the patient shown positive response to treatment with Cimzia based on any of the following measurements? (Check all that showed a positive response to Cimzia therapy):

- Health Assessment Questionnaire Disease Index (HAQ-DI) Visual Analogue scale (VAS)
 Likert scales of global response to pain by the patient/doctor Global Arthritis Score (GAS)
 Clinical Disease Activity Index (CDAI) Simplified Disease Activity Index (SDAI)
 Disease Activity Scale (DAS) score ESR or C-reactive protein (CRP)
 Disease Activity Score based on 28-joint evaluation (DAS28) score Disease Activity Scale (DAS) score
 At least a 20% improvement according to ACR 20% response criteria
 Other (please specify) :

Additional pertinent information:

**CIGNA HealthCare’s coverage position on this and other medications may be viewed online at:
http://www.cigna.com/customer_care/healthcare_professional/coverage_positions**

Please fax completed form to (800)390-9745. Phone requests may be submitted by calling (800)244-6224.

Our standard response time for prescription drug coverage requests is 2-4 business days. If your request is urgent, it is important that you call Pharmacy Services to expedite the request. View our formulary on line at <http://www.cigna.com>.

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