CIMplicity Enrollment and Benefits Verification Form

FAX COMPLETED FORM TO 1-866-949-2469

FOR ASSISTANCE, CALL 1-866-424-6942

CIMZIA® (certolizumab pegol)

STEP 1: PATIENT INFORMATION

Patient Name (First, Last)		Gender ☐ M ☐ F ☐ Other	DOB / /
Street Address		City	
State	ZIP	Email	
Mobile Phone #		Home Phone #	

STEP 2: INSURANCE INFORMATION

☐ Card(s) Attached	Primary Insurance	Group #	Member ID #		Phone
	Secondary Insurance	Group #	Member ID #		Phone
	Pharmacy Insurance	Group #	Member ID #	RX Bin #	Phone

STEP 3: PATIENT HISTORY/DIAGNOSIS (Check all that apply)

	RA	PsA	PSO	AS	CD	nr-axSpA
Diagnosis Code:	☐ M06.9 ☐ Other:_____	☐ L40.5 _____ ☐ Other:_____	☐ L40.0 ☐ Other:_____	☐ M45 _____ ☐ Other:_____	☐ K50 _____ ☐ Other:_____	☐ M45.A _____ ☐ Other:_____

Prior Therapies: ☐ HUMIRA® ☐ ENBREL® ☐ REMICADE® ☐ SIMPONI ARIA® ☐ ENTYVIO® ☐ STELARA® ☐ TALTZ® ☐ TREMFYA® ☐ OTEZLA® ☐ XELJANZ® ☐ RINVOQ™

STEP 4: PRESCRIBER INFORMATION

Prescriber Name (First, Last)			
NPI #	Tax ID #		
Office Contact	Phone #		
Practice/Clinic Name	Fax #		
Street Address	City	State	ZIP

STEP 5: BENEFITS VERIFICATION REQUEST AND PRESCRIPTION INFORMATION

Please complete either the Medical Benefit section OR the Pharmacy Benefit section as it pertains to your patient's needs. I am requesting:

☐ **BENEFITS VERIFICATION ONLY.** ☐ **PRIOR AUTHORIZATION SUPPORT.** ☐ **Medical Assignment of Benefit (AOB) and Pharmacy coverage for CIMZIA Lyophilized Powder.**

FOR YOUR ELIGIBLE nr-axSpA PATIENTS ONLY*

cimplicity® COVERED™

Enroll your nr-axSpA patients in the CIMplicity® Covered™ program. Patients must be prescribed the prefilled syringe and must be injecting at home.

MEDICAL BENEFIT

Formulation: Lyophilized powder	**Dispense**	**Refill**
Loading Dose: NDC #: 50474-700-62 ☐ Inject 400 mg SQ at 0, 2, and 4 weeks.	3 kits - 6 vials	
Maintenance Dose: NDC #: 50474-700-62 ☐ Inject 400 mg SQ every 4 weeks. ☐ Inject 200 mg SQ every 2 weeks.	1 kit - 2 vials	
☐ Inject 400 mg SQ every 2 weeks.	2 kits - 4 vials	

OR

PHARMACY BENEFIT

Formulation: Prefilled Syringe	**Dispense**	**Refill**
Loading Dose: NDC #: 50474-710-81 ☐ Inject 400 mg SQ at 0, 2, and 4 weeks.	1 kit - 6 syringes	
Maintenance Dose: NDC #: 50474-710-79 ☐ Inject 400 mg SQ every 4 weeks. ☐ Inject 200 mg SQ every 2 weeks.	1 kit - 2 syringes	
☐ Inject 400 mg SQ every 2 weeks.	2 kits - 4 vials	

Formulation: Prefilled Syringe	**Dispense**	**Refill**
Loading Dose: NDC #: 50474-710-81 ☐ Inject 400 mg SQ at 0, 2, and 4 weeks.	1 kit - 6 syringes	
Maintenance Dose: NDC #: 50474-710-79 ☐ Inject 400 mg SQ every 4 weeks. ☐ Inject 200 mg SQ every 2 weeks.	1 kit - 2 syringes	

☐ I have sent this prescription to	Specialty Pharmacy:	Pharmacy Phone:	Pharmacy Fax:

By signing below, I certify: 1) The therapy is medically necessary and that this information is accurate to the best of my knowledge; 2) I am disclosing this information to UCB, their affiliates, agents, representatives, business partners, and service providers (together "UCB") to help enable treatment for this Patient; 3) The Patient is aware of, has consented to, and has directed my disclosure of their information to UCB so that UCB may contact the Patient to further enable services for those purposes and that such consent and direction applies to disclosures made through the duration of the Patient's therapy; 4) I will not seek reimbursement from any third party for the support UCB provides; and 5) I am licensed to prescribe the prescription medication identified in this form, the prescription complies with my state-specific prescribing requirements and I appoint UCB as my agent for the limited purposes of conveying this prescription by facsimile only to the dispensing pharmacy. I understand that by signing this form, I am requesting support from UCB for Patients receiving CIMZIA pursuant to an FDA-approved indication. PRESCRIBER SIGNATURE: PRESCRIBER MUST MANUALLY SIGN AND DATE. RUBBER STAMPS AND SIGNATURE BY OTHER OFFICE PERSONNEL FOR THE PRESCRIBER WILL NOT BE ACCEPTED.

☐ Send electronic authorization form to listed patient

PRESCRIBER SIGNATURE	(Signature Required)	Date / /

Please see accompanying Important Safety Information, refer to the full Prescribing Information provided by the UCB representative, and visit CIMZIAhcp.com.

For more information, contact the CIMplicity service center:

Hours: 8am to 8pm ET, Monday-Friday

Fax: 1-866-949-2469

Phone: 1-866-424-6942

Indications

- CIMZIA is indicated for the treatment of adults with moderately to severely active rheumatoid arthritis (RA)
- CIMZIA is indicated for the treatment of adult patients with active psoriatic arthritis (PsA)
- CIMZIA is indicated for the treatment of adults with active ankylosing spondylitis (AS)
- CIMZIA is indicated for reducing signs and symptoms of Crohn's disease (CD) and maintaining clinical response in adult patients with moderately to severely active disease who have had an inadequate response to conventional therapy
- CIMZIA is indicated for the treatment of adults with moderate-to-severe plaque psoriasis (PSO) who are candidates for systemic therapy or phototherapy
- CIMZIA is indicated for the treatment of adults with active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation

Important Safety Information

Contraindications

CIMZIA is contraindicated in patients with a history of hypersensitivity reaction to certolizumab pegol or to any of the excipients. Reactions have included angioedema, anaphylaxis, serum sickness, and urticaria.

Serious Infections

Patients treated with CIMZIA are at increased risk for developing serious infections that may lead to hospitalization or death. Most patients who developed these infections were taking concomitant immunosuppressants such as methotrexate or corticosteroids.

Discontinue CIMZIA if a patient develops a serious infection or sepsis.

Reported infections include:

- **Active tuberculosis (TB), including reactivation of latent TB. Patients with TB have frequently presented with disseminated or extrapulmonary disease. Test patients for latent TB before CIMZIA use and during therapy. Initiate treatment for latent TB prior to CIMZIA use.**
- **Invasive fungal infections, including histoplasmosis, coccidioidomycosis, candidiasis, aspergillosis, blastomycosis, and pneumocystosis. Patients with histoplasmosis or other invasive fungal infections may present with disseminated, rather than localized, disease. Antigen and antibody testing for histoplasmosis may be negative in some patients with active infection. Consider empiric anti-fungal therapy in patients at risk for invasive fungal infections who develop severe systemic illness.**
- **Bacterial, viral, and other infections due to opportunistic pathogens, including Legionella and Listeria.**

Carefully consider the risks and benefits of treatment with CIMZIA prior to initiating therapy in the following patients: with chronic or recurrent infection; who have been exposed to TB; with a history of opportunistic infection; who resided in or traveled in regions where mycoses are endemic; with underlying conditions that may predispose them to infection. Monitor patients closely for the development of signs and symptoms of infection during and after treatment with CIMZIA, including the possible development of TB in patients who tested negative for latent TB infection prior to initiating therapy.

- Do not start CIMZIA during an active infection, including localized infections.
- Patients older than 65 years, patients with co-morbid conditions, and/or patients taking concomitant immunosuppressants may be at greater risk of infection.
- If an infection develops, monitor carefully and initiate appropriate therapy.

Malignancy

Lymphoma and other malignancies, some fatal, have been reported in children and adolescent patients treated with TNF blockers, of which CIMZIA is a member. CIMZIA is not indicated for use in pediatric patients.

- Consider the risks and benefits of CIMZIA treatment prior to initiating or continuing therapy in a patient with known malignancy.
- In clinical trials, more cases of malignancies were observed among CIMZIA-treated patients compared to control patients.
- In CIMZIA clinical trials, there was an approximately 2-fold higher rate of lymphoma than expected in the general U.S. population. Patients with rheumatoid arthritis, particularly those with highly active disease, are at a higher risk of lymphoma than the general population.
- Malignancies, some fatal, have been reported among children, adolescents, and young adults being treated with TNF blockers. Approximately half of the cases were lymphoma, while the rest were other types of malignancies, including rare types associated with immunosuppression and malignancies not usually seen in this patient population.
- Postmarketing cases of hepatosplenic T-cell lymphoma (HSTCL), a rare type of T-cell lymphoma, have been reported in patients treated with TNF blockers, including CIMZIA. These cases have had a very aggressive disease course and have been fatal. The majority of reported TNF blocker cases have occurred in patients with Crohn's disease or ulcerative colitis, and the majority were in adolescent and young adult males. Almost all of these patients had received treatment with azathioprine or 6-mercaptopurine concomitantly with a TNF blocker at or prior to diagnosis. Carefully assess the risks and benefits of treating with CIMZIA in these patient types.
- Cases of acute and chronic leukemia were reported with TNF blocker use.

Heart Failure

- Worsening and new onset congestive heart failure (CHF) have been reported with TNF blockers. Exercise caution and monitor carefully.

Hypersensitivity

- Angioedema, anaphylaxis, dyspnea, hypotension, rash, serum sickness, and urticaria have been reported following CIMZIA administration. If a serious allergic reaction occurs, stop CIMZIA and institute appropriate therapy. The needle shield inside the removable cap of the CIMZIA prefilled syringe contains a derivative of natural rubber latex which may cause an allergic reaction in individuals sensitive to latex.

Hepatitis B Virus Reactivation

- Use of TNF blockers, including CIMZIA, may increase the risk of reactivation of hepatitis B virus (HBV) in patients who are chronic carriers. Some cases have been fatal.
- Test patients for HBV infection before initiating treatment with CIMZIA.
- Exercise caution in patients who are carriers of HBV and monitor them before and during CIMZIA treatment.
- Discontinue CIMZIA and begin antiviral therapy in patients who develop HBV reactivation. Exercise caution when resuming CIMZIA after HBV treatment.

Neurologic Reactions

- TNF blockers, including CIMZIA, have been associated with rare cases of new onset or exacerbation of central nervous system and peripheral demyelinating diseases, including multiple sclerosis, seizure disorder, optic neuritis, peripheral neuropathy, and Guillain-Barré syndrome.

Hematologic Reactions

- Rare reports of pancytopenia, including aplastic anemia, have been reported with TNF blockers. Medically significant cytopenia has been infrequently reported with CIMZIA.
- Consider stopping CIMZIA if significant hematologic abnormalities occur.

Drug Interactions

- Do not use CIMZIA in combination with other biological DMARDs.

Autoimmunity

- Treatment with CIMZIA may result in the formation of autoantibodies and, rarely, in development of a lupus-like syndrome. Discontinue treatment if symptoms of a lupus-like syndrome develop.

Immunizations

- Patients on CIMZIA should not receive live or live-attenuated vaccines.

Adverse Reactions

- The most common adverse reactions in CIMZIA clinical trials (≥8%) were upper respiratory infections (18%), rash (9%), and urinary tract infections (8%).

Please see full Prescribing Information provided by the UCB representative, and visit CIMZIAhcp.com.

Patient Authorization to Use/Disclose Health Information

cimzia® (certolizumab pegol)

By signing this form, I hereby authorize each of my physicians, pharmacists (including any specialty pharmacy that receives my prescription for a UCB medication), my other healthcare providers (together, "Providers"), and each of my health insurers (together, "Insurers") to disclose information related to my medical condition and treatment (including prescription information), my health insurance coverage and policy number, my name, mailing and email addresses, telephone number, date of birth, and Social Security Number (together, "Protected Health Information"), to UCB, Inc. and its agents, service providers, contractors, and representatives (together, "UCB"), so that UCB may: (i) enroll me in, and contact me about, UCB medication support programs and/or related market research; (ii) provide me with educational materials, information, and services related to UCB medications; (iii) verify, investigate, assist with, and coordinate my coverage for a UCB medication with my Insurers and Providers; (iv) conduct market analyses or other commercial activity, including aggregating my Protected Health Information with other data for such analyses; (v) assist with analysis related to quality, efficacy, and safety for UCB medication; (vi) de-identify my Protected Health Information for use for any purpose under applicable law; and (vii) send marketing communications to me, which may be delivered under the Communication Terms described below if I additionally agree to those terms.

I understand that once my Protected Health Information has been disclosed to UCB, federal privacy laws may no longer protect the information and it may be subject to re-disclosure. However, I understand that UCB and other parties authorized to receive my health information pursuant to this Authorization agree to protect my health information by using and disclosing it only for purposes authorized in this Authorization or as required by law or regulations. I understand that one or more Provider and/or Insurer may receive payment from UCB for disclosing my Protected Health Information for some or all of the purposes listed above.

I understand that I am not required to sign this Authorization, and that if I decline to sign, it will not affect my treatment (including the receipt of UCB medication), payment for treatment, insurance enrollment, or eligibility for insurance benefits, but it may mean that I will not receive the other services described above.

I understand that I may revoke this Authorization at any time by (1) by mailing a letter requesting such cancellation to UCBCares 1950 Lake Park Drive, Smyrna, GA 30080; or (2) by informing my Providers in writing that I do not want them to share any information with UCB. UCB shall provide timely notification of my revocation of this Authorization to my Providers and Insurers. Once my Providers and Insurers receive and process the notice of revocation of this Authorization, my Providers and Insurers may no longer make disclosures of my Protected Health Information to UCB as permitted by this Authorization. This Authorization expires on December 31, 2030, or earlier if required by state law, unless otherwise revoked as outlined above, or unless a shorter period is mandated by the law of my state of residence. I understand that I have the right to receive a copy of this Authorization when it is signed.

I agree to be contacted by UCB by mail, email, telephone, and text messages, at the number(s) and address(es) provided in the Patient Information section of the Enrollment and Benefits Verification Form, to communicate with me for all of the purposes described in this Authorization. I understand that my wireless service provider's message and data rates may apply.

I agree to this Patient Authorization Form	PATIENT SIGNATURE (Signature required)	Date / /

Please refer to the Medication Guide provided to you and discuss it with your doctor, or visit CIMZIA.com.

For more information, contact the CIMplicity service center:
Hours: 8am to 8pm ET, Monday-Friday

Fax: 1-866-949-2469
Phone: 1-866-424-6942

*CIMplicity Covered Eligibility: Eligible patients with a valid prescription for CIMZIA can receive treatment with the CIMZIA Prefilled Syringe at no cost for up to 2 years or until the patient's coverage is approved, whichever comes first. The program is not available to patients whose medications are reimbursed, in whole or in part, by Medicare, Medicaid, TRICARE, or any other federal or state program or where otherwise prohibited by law. Patients may be asked to reverify insurance coverage status during the course of the program. No purchase necessary. The program is not health insurance, nor is participation a guarantee of insurance coverage. Limitations may apply.