EXPRESS SCRIPTS®

Clear Print

Prior Authorization Request

CIMZIA (certolizumab pegol)

Instructions

Please complete Part A and have your physician complete Part B. Completion and submission is not a guarantee of approval. Any fees related to the completion of this form are the responsibility of the plan member. Drugs in the Prior Authorization Program may be eligible for reimbursement if the patient does not qualify for coverage under a primary plan or a government program. Drugs used for indications not approved by Health Canada may be denied. For Quebec plan members, RAMQ exception drug criteria may apply. The decision for approval versus denial is based on pre-defined clinical criteria, primarily based on Health Canada approved indication(s) and on supporting evidence-based clinical protocols. The plan member will be notified whether their request has been approved or denied. Please note that you have the right to appeal the decision made by Express Scripts Canada.

Part A – Patient

Patient information

First Name:	Last Name:	
Insurance Carrier Name/Number:		
Group Number:	Client ID:	
Date of Birth (YYYY/MM/DD):	Relationship: ☐ Employee ☐ Spouse ☐ Dependent	
Language: ☐ English ☐ French	Gender: ☐ Male ☐ Female	
Address:		
City:	Province:	Postal Code:
Email address:		
Telephone (home):	Telephone (cell):	Telephone (work):

Coordination of benefits

Patient Assistance Program	Is the patient enrolled in any patient assistance program? ☐ Yes ☐ No Contact Name: _____ Fax: _____
Provincial Coverage	Has the patient applied for reimbursement under a provincial plan? ☐ Yes ☐ No ☐ N/A What is the coverage decision of the drug? ☐ Approved ☐ Denied ***Attach decision letter****
Primary Coverage	Has the patient applied for reimbursement under a primary plan? ☐ Yes ☐ No ☐ N/A What is the coverage decision of the drug? ☐ Approved ☐ Denied ***Attach decision letter****

Authorization

On behalf of myself and my eligible dependents, I authorize my group benefit provider, and its agents, to exchange the personal information contained on this form. I give my consent on the understanding that the information will be used solely for purposes of administration and management of my group benefit plan. This consent shall continue so long as my dependents and I are covered by, or are claiming benefits under the present group contract, or any modification, renewal, or reinstatement thereof.

_____ _____

Plan Member Signature Date

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Part B – Prescriber

Please see instructions on page 1 and complete all sections below. Incomplete forms may result in automatic denial. Please do **not** provide genetic test information or results.

SECTION 1 – DRUG REQUESTED

CIMZIA (certolizumab pegol)	☐ New request	☐ Renewal request*	
Dose	Administration (ex: oral, IV, etc)	Frequency	Duration

Site of drug administration:

☐ Home ☐ Physician's office/Infusion clinic ☐ Hospital (outpatient) ☐ Hospital (inpatient)

* Please submit proof of prior coverage if available

SECTION 2 – ELIGIBILITY CRITERIA

1. **Please indicate if the patient satisfies the below criteria:**

Rheumatoid Arthritis

- ☐ For the treatment of moderately to severely active rheumatoid arthritis in an adult, AND
- ☐ The patient has had an inadequate response to a minimum 12-week trial of methotrexate in combination with another disease modifying anti-rheumatic drug (DMARD) *(Please list prior therapies in the chart below)*, OR
- ☐ Where combinations of non-biologic DMARDs are impossible, the patient has tried 3 consecutive non-biologic DMARDs, unless patient has a documented intolerance to DMARDs *(Please list prior therapies in the chart below)*, AND
- ☐ CIMZIA will be used in combination with methotrexate or other DMARDs unless there is a documented intolerance

Psoriatic Arthritis

- ☐ For the treatment of psoriatic arthritis in an adult, AND
- ☐ The patient has had an inadequate response or has a documented intolerance to at least 2 disease modifying anti-rheumatic drugs (DMARDs), or to another biologic response modifier *(Please list prior therapies in the chart below)*

Ankylosing Spondylitis

- ☐ For the treatment of ankylosing spondylitis in an adult, AND
- ☐ The patient has a Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) score of 4 or greater on a 10-point scale, AND
- ☐ The patient has had an inadequate response or has a documented intolerance to at least 2 non-steroidal anti-inflammatory drugs (NSAIDs) for a minimum of 2 weeks each, or to at least 2 disease modifying anti-rheumatic drugs (DMARDs) for a minimum of 3 months, or to another biologic response modifier *(Please list prior therapies in the chart below)*

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Plaque Psoriasis

- ☐ For the treatment of moderate to severe plaque psoriasis in an adult, AND
- ☐ The patient has an affected body surface area (BSA) of 10% or greater, or there is involvement of the patient's face, hands, feet or genital region, AND
- ☐ The patient has a Psoriasis Area and Severity Index (PASI) score of 10 or greater, AND
- ☐ The patient has had an inadequate response or has a documented intolerance to phototherapy, unless it is inaccessible, AND
- ☐ The patient has had an inadequate response or has a documented intolerance to conventional systemic therapy, or to another biologic response modifier *(Please list prior therapies in the chart below)*

Non-Radiographic Axial Spondyloarthritis

- ☐ For the treatment of non-radiographic axial spondyloarthritis in an adult, AND
- ☐ The patient has objective signs of inflammation as indicated by elevated C-reactive protein (CRP) and/or magnetic resonance imaging (MRI), AND
- ☐ The patient has had an inadequate response or has a documented intolerance to at least 2 non-steroidal anti-inflammatory drugs (NSAIDs) for a minimum of 2 weeks each, or to another biologic response modifier *(Please list prior therapies in the chart below)*

OR

- ☐ None of the above criteria applies.

Relevant additional information:

2. Please list previously tried therapies

Drug	Dosage and administration	Duration of therapy		Reason for cessation	
		From	To	Inadequate response	Allergy/ Intolerance
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

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SECTION 3 – PRESCRIBER INFORMATION

Physician's Name:	
Address:	
Tel:	Fax:
License No.:	Specialty:
Physician Signature:	Date:

Please fax or mail the completed form to Express Scripts Canada®

Fax: Express Scripts Canada Clinical Services
1 (855) 712-6329

Mail: Express Scripts Canada Clinical Services
5770 Hurontario Street, 10th Floor
Mississauga, ON L5R 3G5