Fax Referral To: 800-323-2445
Phone: 866-278-6634

Cimzia®
Enrollment Form
For Blue Cross Blue Shield of Rhode Island Members

Date: _________ **Needs by Date (Please Specify):** ________

Ship to: ☐ Patient ☐ Office ☐ Other: ____________

PATIENT INFORMATION

(Complete the following or ***send patient demographic sheet****)*

Patient Name: ____________
Address: ____________
City, State, Zip: ____________
Home Phone: ____________
Alternate Phone: ____________
SS #: ____________
Insurance ID: ____________
Date of Birth: ____________ Gender: ____________

PRESCRIBER INFORMATION

Prescriber's Name: ____________
State License #: ____________ UPIN: ____________
DEA #: ____________ NPI #: ____________
Group or Hospital: ____________
Address: ____________
City, State Zip: ____________
Phone: ____________ Fax: ____________
Contact Person: ____________
Contact Phone: ____________

INSURANCE INFORMATION *(If available, please copy and attach the front and back of insurance and prescription drug card)*

Primary Insurance: Subscriber: ____________ Subscriber ID#: ____________ Name of Insurer: **Blue Cross Blue Shield of RI**
Secondary Insurance: Subscriber: ____________ Subscriber ID#: ____________ Name of Insurer: ____________

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 Code): ☐ ____________ • Date of Diagnosis: ____________

Approval Criteria: CHECK ALL BOXES THAT APPLY

Please note: Any areas that are not filled out will be considered not applicable to your patient and MAY AFFECT THE OUTCOME OF THIS REQUEST

Crohn's Disease:

- Patient is 18 years of age or older. ☐ Yes ☐ No
- Patient has a diagnosis of moderate to severe Crohn's Disease. ☐ Yes ☐ No
- Patient has had an inadequate response or is unable to tolerate conventional therapies [e.g. sulfasalazine, mesalamine products, corticosteroids, immunosuppressants (6-mercaptopurine), azathioprine, cyclosporine, or methotrexate)] ☐ Yes ☐ No
- Is this request for initial dosing? ☐ Yes ☐ No

Rheumatoid Arthritis:

- Patient is 18 years of age or older. ☐ Yes ☐ No
- Patient has moderately to severely active rheumatoid arthritis. ☐ Yes ☐ No
- Patient has failed to respond to, is intolerant of, or has a medical contraindication to one or more non-biologic disease modifying anti-rheumatic agents (DMARDs). ☐Yes ☐No

Cimzia® (certolizumab pegol) is considered NOT medically necessary for patients with any of the following:

- Individuals with congestive heart failure (CHF) who develop new symptoms or worsening symptoms of pre-existing CHF
- Tuberculosis or other active serious infections, including chronic or localized infections
- Individuals who have not had a tuberculin skin test to rule out latent tuberculosis
- Multiple sclerosis or other demyelinating neurological disease
- Concurrent administration of live (including attenuated) vaccines with certolizumab pegol (Cimzia®)
- Currently receiving other TNF blocking agents or anakinra (Kineret®)
- Any other indication not listed

Please respond to all of the following questions regarding your patient:

- Prior to initiating Cimizia, has the patient had an inadequate response to Remicade, Enbrel, or Humira? ☐ Yes ☐ No
- Does the patient have CHF or has the patient developed new symptoms or worsening symptoms of pre-existing CHF? ☐ Yes ☐ No
- Does the patient have Tuberculosis or any other active serious infections, including chronic or localized infections? ☐ Yes ☐ No
- Has the patient had a tuberculin skin test to rule out latent tuberculosis? ☐ Yes ☐ No
- Does the patient have multiple sclerosis or other demyelinating neurological disease? ☐ Yes ☐ No
- Is the patient receiving or will the patient be receiving concurrent administration of live (including attenuated) vaccines with certolizumab pegol (Cimzia®)? ☐ Yes ☐ No
- Is the patient currently receiving other TNF blocking agents or anakinra (Kineret®)? ☐ Yes ☐ No

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Cimzia® (certolizumab pegol)	☐ 200mg		Specify: _____ QL: 1 pack (2x200mg vials) per 30 days Note: 3 additional packs (2x200mg vials) may be approved **one time only** for the first month for initial dosing, if applicable and requested.	

PRODUCT SUBSTITUTION PERMITTED (Date) ____________ DISPENSE AS WRITTEN (Date) ____________

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. Cimzia PAB 122309