CIMplicity Enrollment and Benefits Verification Form
Rheumatology/GI

FAX COMPLETED FORM TO 1-866-949-2469
FOR ASSISTANCE, CALL 1-866-424-6942

cimplicity® | cimzia® (certolizumab pegol)

2023

STEP 1: PATIENT INFORMATION

*Patient Name (First, Middle Initial, 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: CLINICAL INFORMATION Please refer to the full Prescribing Information for recommended evaluation prior to treatment.

Diagnosis Code: (Select all that apply) Please complete blanks where applicable	*RA ☐ M06.9 ☐ Other:_____	*PsA ☐ L40.5 _____ ☐ Other:_____	*PSO ☐ L40.0 ☐ Other:_____	*AS ☐ M45 _____ ☐ Other:_____	*CD ☐ K50 _____ ☐ Other:_____	*nr-axSpA ☐ M45.A _____ ☐ Other: _____	**Patient Height** (ft, in): _____
Prior Treatment Failures, Contraindications, or Intolerances (Select all that apply)	☐ HUMIRA®	☐ ENBREL®	☐ REMICADE®	☐ SIMPONI ARIA®	☐ ENTYVIO®	☐ STELARA®	☐ TALTZ®
	☐ ORENCIA®	☐ OTEZLA®	☐ XELJANZ®	☐ RINVOQ™	☐ No previous biologic or systemic agent	Other:	**Patient Weight** (lb): _____

STEP 4: PRESCRIBER INFORMATION

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

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.**

MEDICAL BENEFIT

***Formulation:** CIMZIA (certolizumab pegol) 200 mg Lyophilized Powder Vial	**Dispense**	**Refill**
***Loading Dose:** NDC #: 50474-700-62 ☐ 400 mg SQ (2 x 200 mg/ML) at weeks 0, 2, and 4.	3 kits - 6 vials	
***Maintenance Dose:** NDC #: 50474-700-62 ☐ Inject 400 mg SQ (2 x 200 mg/ML) every 4 weeks. ☐ Inject 200 mg/ML SQ every 2 weeks.	1 kit - 2 vials	
☐ Inject 400 mg SQ (2 x 200 mg/ML) every 2 weeks.	2 kits - 4 vials	

OR

PHARMACY BENEFIT

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

FOR YOUR ELIGIBLE nr-axSpA PATIENTS ONLY*

cimplicity® COVERED*

Nr-axSpA patients must be prescribed the prefilled syringe and must be injecting at home. Office must complete the Pharmacy Benefit information to the left as well as the CIMplicity Covered benefit below.

***Formulation:** CIMZIA 200 mg/ML Prefilled Syringe	**Dispense**	**Refill**
***Loading Dose:** NDC #: 50474-710-81 ☐ Inject 400 mg SQ (2 x 200 mg/ML) at weeks 0, 2, and 4.	1 kit - 6 syringes	
***Maintenance Dose:** NDC #: 50474-710-79 ☐ Inject 400 mg SQ (2 x 200 mg/ML) every 4 weeks. ☐ Inject 200 mg/ML 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 any means under applicable law only to the dispensing pharmacy; and 6) I hereby authorize UCB HUB to initiate and to complete and submit prior authorization (PA) request to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature. 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 follow your state's prescribing guidelines for electronic prescriptions (if applicable). 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), and other of my 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(s) and/or Insurer(s) may receive payment from UCB for disclosing my Protected Health Information (PHI) for some or all of the purposes listed above.

I understand that I am not required to sign this Authorization, and revoking my authorization means my physicians, pharmacies, and health plans, as well as UCB, Inc., may no longer rely on the authorization to use or disclose my PHI, but it will not affect previous disclosures by them pursuant to this authorization.

I understand that I may revoke this Authorization at any time by (1) mailing a letter, including my First Name, Last Name, Date of Birth, Gender, and ZIP Code, 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 10 years from the date it was signed, or earlier 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 and telephone, at the number(s) and address(es) provided in the Patient Information section of this Enrollment & Benefits Verification Form, to communicate with me for all of the purposes described in this Authorization.

I agree to this Patient Authorization Form	PATIENT/AUTHORIZED SURROGATE SIGNATURE REQUIRED (Signature required)	Date
Relationship to Patient:		/ /

☐ **I agree** to receive text messages from CIMplicity. Message and data rates may apply. You will receive two messages per month. Text STOP to cancel. Text HELP for help. If you have questions, contact the CIMZIA Nurse Navigator at 1-844-822-6877. View the complete Terms of Use at CIMZIA.com. For more information on how UCB will use your information, please view our privacy policy at CIMZIA.com.

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.