CIMplicity Benefit Verification and Enrollment Form

Fax completed form to CIMplicity: 1-866-949-2469

cimplicity® | cimzia® (certolizumab pegol)

PATIENT INFORMATION

*Patient Name (First, Middle Initial, Last)		*Gender assigned at birth ☐ Male ☐ Female	*DOB / /
*Street Address			Weight
*City	*State	*ZIP	*Email
*Mobile Phone #	Home Phone #		*Preferred Language ☐ English ☐ Spanish ☐ Other:_____

*INSURANCE INFORMATION

☐ Front and back copies of the patient's medical and pharmacy insurance card(s) attached ☐ No Insurance

Primary Insurance	Group #	Member ID #		Phone
Secondary Insurance	Group #	Member ID #		Phone
Pharmacy Insurance	Group #	Member ID #	RX Bin #	Phone

CLINICAL INFORMATION

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

Prior Treatment Failures, Contraindications, or Intolerances (Select all that apply)	☐ COSENTYX®	☐ DMARD	☐ ENBREL®	☐ HUMIRA®	☐ OTEZLA®	☐ SILIQ®	☐ SIMPONI ARIA®	☐ SKYRIZI®
	☐ STELARA®	☐ TALTZ®	☐ XELJANZ®	☐ None	Other:			

Allergies:	Secondary Diagnosis:

*PRESCRIPTION INFORMATION

Please complete either the Medical Benefit section OR the Pharmacy Benefit section, as applicable.

I am requesting: ☐ **MEDICAL BENEFIT VERIFICATION** ☐ **PHARMACY BENEFIT VERIFICATION** ☐ **PRIOR AUTHORIZATION SUPPORT**

☐ Please enroll patient into **CIMplicity Covered®**; available for eligible, commercially insured patients using CIMZIA Prefilled Syringe who experience a coverage delay or denial (additional terms apply)†

Loading Dose	☐ NDC: 50474-700-62 Lyophilized Powder Vial **OR** ☐ NDC 50474-710-81 Prefilled Syringe 1 Starter Kit	**Dispense**	**Refill**
RA, PsA, AS, nr-axSpA, CD patients **OR** **PSO** patients prescribed 200 mg every 2 weeks	☐ 400 mg SQ (2 x 200 mg/mL) at weeks 0, 2, 4.	1 kit (6 syringes) **OR** 3 kits (6 vials)	0

Maintenance Doses (Indication Specific)	☐ NDC 50474-700-62 Lyophilized Powder Vial		☐ NDC 50474-710-79 Prefilled Syringe		
RA, PsA, AS, nr-axSpA	☐ Inject 400 mg SQ (2 x 200 mg/mL) every 4 weeks	**OR**	☐ Inject 200 mg/mL SQ every 2 weeks	1 kit (2 syringes or 2 vials)	____
PSO	☐ Inject 400 mg SQ (2 x 200 mg/mL) every 2 weeks	**OR**	☐ For some patients weighing less than/equal to 90 kg: Inject 200 mg SQ (1 x 200 mg/mL) every 2 weeks	2 kits (4 syringes or 4 vials) **OR** 1 kit (2 syringes or 2 vials)	____
CD	☐ Inject 400 mg SQ (2 x 200 mg/mL) every 4 weeks			1 kit (2 syringes or 2 vials)	____

PRESCRIBER INFORMATION

*Prescriber Name (First, Last)		*NPI #	*Tax ID #
*Practice/Clinic Name		*Office Contact	
*Street Address	*City	*State	*ZIP
*Phone #	*Fax #	Supervising Physician	NPI #
☐ 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; 5) I am licensed to prescribe the prescription medication identified in this form; 6) the prescription complies with my state-specific prescribing requirements, and I appoint UCB as my agent for the limited purpose of conveying this prescription by any means under applicable law only to the dispensing pharmacy; and 7) I hereby authorize UCB's patient support program vendor to submit this Enrollment Form to the dispensing pharmacy as my signature. I understand that by signing this form, I am requesting support from UCB for the above-referenced patient who has been prescribed CIMZIA. PRESCRIBER SIGNATURE: PRESCRIBER MUST MANUALLY SIGN AND DATE. RUBBER STAMPS AND SIGNATURE BY OTHER OFFICE PERSONNEL FOR THE PRESCRIBER WILL NOT BE ACCEPTED.

Prescriber Signature Required

☐ **Patient unable to provide consent. Please send digital request to obtain Patient Authorization to Use/Disclose Health Information.**

DISPENSE AS WRITTEN **OR** **SUBSTITUTION PERMITTED** ***Date Signed**

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.

CA, MA, NC, & PR: Interchange is mandated unless prescriber writes "No Substitution." ATTN: NY and IA, please submit electronic prescription.

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

For CIMZIA® (certolizumab pegol)

By signing this **Patient Authorization to Use/Disclose Health Information form** ("Authorization"), 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, and date of birth (together, "Health Information"), to UCB, Inc. and its agents, service providers, contractors, and representatives (together, "UCB"). My Health Information will be shared with UCB so that UCB may: (i) enroll me in, and contact me about, patient support programs and/or related market research for UCB medications; (ii) provide me with educational materials and information related to UCB medications; (iii) verify, investigate, assist with, and coordinate my coverage for a UCB medication with my Insurers and Providers; (iv) determine my eligibility for and help me access savings, interim care and/or free drug programs for UCB medications; (v) conduct market research and/or analyses or other commercial activity, including aggregating my Health Information with other data for such analyses; (vi) assist with analysis related to quality, efficacy, and safety for UCB medications; (vii) de-identify my Health Information for use for any purpose under applicable law.

I understand that I do not have to sign this Authorization and choosing not to sign will not affect my ability to receive treatment from my Providers or payment from my Insurers. However, if I do not sign this form, UCB may not be able to provide me with certain patient support. Once my Health Information has been disclosed to UCB, I understand that federal privacy laws may no longer protect this information. 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 also understand that one or more Providers and/or Insurers may receive payment from UCB for disclosing my Health Information for some or all of the purposes listed above.

I understand that this Authorization is voluntary and that I am not required to sign this Authorization. I may revoke this Authorization at any time (1) by mailing a letter, including my First Name, Last Name, Date of Birth, Gender, and ZIP Code, requesting such cancellation to UCBCares® at 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. I understand that 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 made by them pursuant to this Authorization. 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 Health Information to UCB as permitted by this Authorization.

This Authorization expires 10 years from the date it was signed unless a shorter period is mandated by the law of my state of residence, or unless otherwise revoked as outlined above. I understand that I have the right to receive a copy of this Authorization once it is signed.

Patient Signature (Patient or Patient Representative)	Patient/Patient Representative Name	Date
		/ /

☐ Court Appointed ☐ Guardian ☐ Power of Attorney (including for healthcare decisions) ☐ Other

☐ **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.

☐ **I agree** that I am a U.S. resident and give UCB permission to send me information or contact me and/or my healthcare provider regarding my disease as well as information on other related treatments, products, and services, and for marketing and informational purposes by phone, email, or mail. I understand that UCB will not sell my name, address, email address, or any other information to any other third party (other than UCB's agents, service providers, contractors, and representatives) for their own marketing use.

☐ **I agree** to receive communications from UCB (as defined above), including but not limited to calls made with an autodialer or prerecorded voice at the phone number(s) provided to provide me with insurance coverage and financial assistance resources and information, injection support, and for other non-marketing purposes. If I have designated a patient representative, he or she also agrees hereby to receive such communications from UCB for the purposes described above at the phone number(s) provided. I understand that I (and, if applicable, my patient representative) can opt out of these communications at any time by mailing a letter, including my First Name, Last Name, Date of Birth, Gender, and ZIP Code, requesting such cancellation to UCBCares at 1950 Lake Park Drive, Smyrna, GA 30080.

Patient Signature (Patient or Patient Representative)	Patient/Patient Representative Name	Date
		/ /

☐ Court Appointed ☐ Guardian ☐ Power of Attorney (including for healthcare decisions) ☐ Other

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 www.CIMZIA.com.

For more information, contact the CIMplicity® service center
HOURS: 8:00 AM to 8:00 PM ET, Monday through Friday

FAX: 1-866-949-2469
PHONE: 1-866-4CIMZIA (1-866-424-6942)
WEBSITE: www.cimzia.com

†CIMplicity Covered® (the "Program") provides CIMZIA® (certolizumab pegol) Prefilled Syringe to eligible patients for $0 per dose for up to two (2) years or until the patient's commercial insurance plan makes a final determination of coverage (i.e., either approves coverage or issues a final denial of coverage for the drug), whichever occurs earlier. Eligible patients must have commercial insurance, a valid prescription for CIMZIA Prefilled Syringe consistent with FDA-approved product labeling, and a denial of insurance coverage based on documented submission of a prior authorization request. To maintain eligibility in the Program, an appeal of the coverage denial (or documentation as may otherwise be required by the payer) must be submitted within sixty (60) days following the prior authorization denial. Program is not available (1) to patients whose prescriptions are reimbursed, in whole or in part, under Medicare (including Medicare Part D), Medicaid, or any other federal- or state-funded healthcare programs (including any state prescription drug assistance programs and the Government Health Insurance Plan available in Puerto Rico), (2) where a patient's insurance covers the drug, (3) to uninsured or cash-paying patients, or (4) where otherwise prohibited by law. Product shall be dispensed pursuant to Program rules and federal and state laws. Patients may be asked to re-verify insurance coverage status during participation in the Program. No purchase necessary. Program is not health insurance, nor is participation a guarantee of insurance coverage. Limitations may apply. This Program is not transferrable and cannot be combined with any other savings, free trial, or similar offer for the specified prescription. The patient, or healthcare provider on the patient's behalf, must not submit any claim for reimbursement for product provided under this Program to any third-party payer. UCB, Inc. reserves the right to end or amend this Program without notice.