For Illustrative Purposes Only. Not an Actual Patient.

CIMplicity Enrollment and Benefits Verification Form
Dermatology Prefilled Syringe

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

cimplicity | cimzia (certolizumab pegol)

July 2022

Step 1: PATIENT INFORMATION

First Name / Middle Initial / Last Name: Jane M Smith		Gender: ☐ M ☑ F ☐ Other	DOB: 8/13/1981
Street Address: 1234 Carter Street		City: Kansas City	
State: KS	Zip: 66101	Email: janemarys81@aol.com	
Mobile Phone #: 913-321-2234		Home Phone #: 913-338-2234	

Step 2: INSURANCE INFORMATION

☑ Card(s) Attached	Primary Insurance: BCBS	Group #: 3456	Member ID #: 123567-8904			Phone: 913-550-1234
	Secondary Insurance:	Group #:	Member ID #:			Phone:
	Pharmacy Insurance: BCBS	Group #: 7891	Member ID #: 123567-8904	RX Bin #: 1234		Phone: 800-443-1234

Step 3: CLINICAL INFORMATION
Please refer to the full Prescribing Information for recommended evaluation prior to treatment.

Prior Treatment Failures, Contraindications, or Intolerances (select all that apply)

☐ Methotrexate	☑ Phototherapy	☐ Otezla®	☑ Humira®	☐ Enbrel®	☐ Taltz®	☐ Cosentyx®	☐ Tremfya®	
☐ Skyrizi®	☐ Avsola®	☐ Stelara®	☐ Siliq®	☑ Illumya®	☑ No previous biologic or systemic agent	Other:		

ICD 10: ☑ L40.0 Psoriasis Other:

Patient Height (ft, in): 5' 7" Patient Weight (lb): 145

Step 4: PRESCRIBER INFORMATION

Prescriber Name (Last): Barry		Prescriber Name (First): Jessica	
Specialty: Dermatology		Tax ID #: 1234567893	
Office Contact: John Doe		Phone #: 913-902-2038	
Practice/Clinic Name: Barry Medical		Fax #: 913-902-2037	
Street Address: 9087 Field Street	City: Kansas City	State: KS	Zip: 66401
Supervising Physician: Catherine Mackey		NPI #: 3456789123	

Step 5: PRESCRIPTION INFORMATION

Pharmacy Prescription *(Fill for ALL patients)*			**CIMplicity® Covered™ Program** *(Commercial Insurance Only)*		
1. CIMZIA® (certolizumab pegol) 200 mg/ML Prefilled Syringe (Select One) NDC: 50474-710-79	**Dispense**	**Refill**	**1. CIMZIA 200 mg/ML Prefilled Syringe** (Select One) NDC: 50474-710-79	**Dispense**	**Refill**
☑ **Inject 400 mg/ML SQ every 2 weeks**	2 Kits (4 syringes)		☑ **Inject 400 mg/ML SQ every 2 weeks**	2 Kits (4 syringes)	1
☐ **Inject 400 mg/ML SQ every 4 weeks**	1 Kit (2 syringes)		☐ **Inject 400 mg/ML SQ every 4 weeks**	1 Kit (2 syringes)	
☐ **Inject 200 mg/ML SQ every 2 weeks**	1 Kit (2 syringes)		☐ **Inject 200 mg/ML SQ every 2 weeks**	1 Kit (2 syringes)	

2. Please Check Location of First Administration for CIMplicity Covered Pharmacy Shipment ☑ Physician's Office ☐ Patient's Home

3. I Have Sent This Prescription to: Pharmacy Name: Accredo Phone #: 1-844-516-3319 Fax #: 1-888-302-1028

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 act as an agent on behalf of the prescriber 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 Jessica Barry *(Signature Required)* Date: 4/21/22

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

Patient Authorization to Use/Disclose Health Information

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	Jane M. Smith (Signature required)	Date 4/21/22
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 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

Please see **Important Safety Information** and full **Prescribing Information** enclosed, or visit **CIMZIAhcp.com**.

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