145 The West Mall, P.O. Box 110 U
Toronto, ON M8Z 5M4

PRIOR AUTHORIZATION PROGRAM FORM

Cimzia® (Certolizumab)

Instructions:

1. Section 1 to be completed by Plan Member / Patient
2. Section 2 to be completed by Physician (expenses incurred by the completion of this form is at plan member's expense)
3. Section 3 to be completed by Pharmacist

Please fax completed form to NexgenRx Formulary Management to 1-877-639-4369 or mail to 145 The West Mall P.O. Box 110 U, Toronto, Ontario,M8Z-5M4

Section 1: To be completed by Patient

Member's Name: (Last , First)	Card ID Number:	
Patient's Name: (Last, First)	Patient's Date of Birth (dd/mm/yy)	Relationship to Member (please circle) Employee Spouse Dependent

PATIENT CODE

Results of this request to be communicated to:

☐ Pharmacy ☐ Patient / Legal Guardian Named Below ☐ email:

I authorize NexgenRx Inc. (a) to use the personal information disclosed on this form, and any other personal information known to NexgenRx Inc. regarding the above-named patient, for the purpose of assessing this prior authorization request and any related claim and administering the benefit plan under which any such claim is made, and (b) to contact, and to obtain any such personal information from and to disclose any such personal information to, any physician, pharmacist or other health care professional having knowledge of such patient's health relevant to this request and any related claim.

Patient / Legal Guardian Name: _____ Telephone Number: _____

Signature of Patient/ Legal Guardian: _____ Date (dd/mm/yy):_____

Section 2: To be completed by Physician

Drug Name & Strength: CIMZIA 200 MG/ML SYRINGE KIT	DIN: 02331675	Dosage Instructions:

Eligibility for drug coverage is dependent upon the patient meeting at least one of the qualifying criteria listed below. If the patient has another drug plan, prior authorization may cover some or all of the excess not paid by the primary plan.

Please indicate if the patient meets at least one of the following qualifying criteria for drug coverage:

- ❑ To reduce the signs and symptoms, induce major clinical response and reduce progression of joint damage as assessed by X-ray, in adult patients with moderate to severe active rheumatoid arthritis. Cimzia may be used alone in adult patients who do not tolerate methotrexate.
- ❑ CIMZIA alone or in combination with methotrexate (MTX) is indicated for reducing signs and symptoms and inhibiting the progression of structural damage as assessed by X-ray, in adult patients with moderately to severely active psoriatic arthritis (PsA) who have failed one or more disease-modifying anti-rheumatic drugs (DMARDs)
- ❑ To reduce the signs and symptoms in adult patients with active ankylosing spondylitis (AS) who have had an inadequate response to conventional therapy.

Physician Name: (Last, First)	License Number:
Address: (Street, City, Province, Postal Code)	Telephone Number : ( ) - Fax Number: ( ) -
Signature of Physician:	Date (dd/mm/yy)

Section 3: To be completed by Pharmacist

Pharmacy Name:	Provider Number:
Pharmacy Address: (Street, City, Province, Postal Code)	Telephone Number : ( ) - Fax Number: ( ) -
Signature of Pharmacist: _____ Pharmacist's Name: (Print Last, First) _____	

Internal Office Use Only:

Date Received:			Date Approved & By: