Pharmacy Medical Necessity Guidelines: 
Cimzia® (certolizumab pegol)

Effective: July 11, 2017

Prior Authorization Required  ✓ Type of Review – Care Management
Not Covered  Type of Review – Clinical Review  ✓
Pharmacy (RX) or Medical (MED) Benefit RX Department to Review RXUM

This Pharmacy Medical Necessity Guideline applies to the following:

Tufts Health Plan Commercial Plans
✓ Tufts Health Plan Commercial Plans – large group plans
✓ Tufts Health Plan Commercial Plans – small group and individual plans

Tufts Health Public Plans
✓ Tufts Health Direct – Health Connector
☐ Tufts Health Together – A MassHealth Plan
☐ Tufts Health RITogether – A RIte Care + Rhody Health Partners Plan

Tufts Health Freedom Plan products
✓ Tufts Health Freedom Plan - large group plans
✓ Tufts Health Freedom Plan - small group plans

Fax Numbers:
RXUM: 617.673.0988

Note: For Tufts Health Plan Medicare Preferred Members, please refer to the Tufts Health Plan Medicare Preferred Prior Authorization Criteria. Background, applicable product and disclaimer information can be found on the last page.

OVERVIEW

FOOD AND DRUG ADMINISTRATION-APPROVED INDICATIONS

Cimzia (certolizumab pegol) is a tumor necrosis factor (TNF) blocker indicated for:

Ankylosing Spondylitis
Treatment of adults with active ankylosing spondylitis (AS)

Crohn’s Disease
Reducing signs and symptoms of Crohn’s disease and maintaining clinical response in adult patients with moderately to severely active disease who have had an inadequate response to conventional therapy.

Psoriatic Arthritis
Treatment of adult patients with active psoriatic arthritis (PsA)

Rheumatoid Arthritis
Treatment of adults with moderately to severely active rheumatoid arthritis

COVERAGE GUIDELINES

The plan may authorize coverage of Cimzia (certolizumab pegol) for Members, when all of the following criteria are met:

For Ankylosing Spondylitis
1. The Member has a documented diagnosis of active ankylosing spondylitis

AND

2. The prescription is written by a rheumatologist

AND

3. The Member has tried and failed treatment with, has a contraindication to or the provider has indicated clinical inappropriateness of treatment with at least two of the following agents:
   • Humira® (adalimumab)
   • Enbrel® (etanercept)
   • Simponi® (golimumab)

OR

4. The Member is new to the plan and has been stable on Cimzia (certolizumab pegol) prior to enrollment.
For Crohn’s Disease
1. The Member has a documented diagnosis of Crohn’s disease by a gastroenterologist
   AND
2. The Member has demonstrated an inadequate response to an appropriate trial with two or more of
   the following agents:
   • Corticosteroids (e.g., prednisone, prednisolone, methylprednisolone)
   • 5-Aminosalicylates (e.g., sulfasalazine, Azulfidine®, Aproso™, Delzicol™, Pentasa®, Rowasa®,
     Dipentum®, Colazal®)
   • 6-mercaptopurine (6-MP, Purinethol®) and/or azathioprine (Imuran®)
   • Methotrexate (MTX)
   AND
3. The Member has tried and failed treatment with, has a contraindication to or the provider has
   indicated clinical inappropriateness of treatment with Humira® (adalimumab)
   OR
4. The Member is new to the plan and has been stable on Cimzia (certolizumab pegol) prior to
   enrollment.

For Psoriatic Arthritis
1. The Member has a documented diagnosis of psoriatic arthritis
   AND
2. The prescription is written by a rheumatologist
   AND
3. The Member has a documented inadequate response or inability to take methotrexate OR
   sulfasalazine at maximal doses for three months.
   AND
4. The Member has tried and failed treatment with, has a contraindication to or the provider has
   indicated clinical inappropriateness of treatment with at least two of the following agents:
   • Humira® (adalimumab)
   • Enbrel® (etanercept)
   • Simponi® (golimumab)
   • Stelara® (ustekinumab)
   OR
5. The Member is new to the plan and has been stable on Cimzia (certolizumab pegol) prior to
   enrollment.

For Rheumatoid Arthritis
1. The Member has a documented diagnosis of Rheumatoid Arthritis by a rheumatologist
   AND
2. The Member must have an inadequate response to methotrexate after three months at optimal
   doses or an inability to take methotrexate.
   AND
3. The Member has tried and failed treatment with, has a contraindication to or the provider has
   indicated clinical inappropriateness of treatment with at least two of the following agents:
   • Humira® (adalimumab)
   • Enbrel® (etanercept)
   • Simponi® (golimumab)
   OR
4. The Member is new to the plan and has been stable on Cimzia (certolizumab pegol) prior to
   enrollment.

Note: Maximal doses of methotrexate are defined as 15mg to 25mg per week depending on the
patient’s tolerance.
LIMITATIONS
1. Samples, free goods or similar offerings of Cimzia (certolizumab) do not qualify for an established clinical response and will not be considered for prior authorization.
2. Coverage of Cimzia prefilled syringe is limited to 28-day supplies as follows:
   • Cimzia 200 mg syringe – 6 syringes per 28 days (initial 4 weeks) then 2 syringes per 28 days thereafter.

CODES
Medical billing codes may not be used for these medications. These medications must be obtained via the Member’s pharmacy benefit.

REFERENCES


**APPROVAL HISTORY**

September 9, 2008: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

- January 1, 2010: Removal of Tufts Medicare Preferred language (separate criteria have been created specifically for Tufts Medicare Preferred).
- November 9, 2010: Added Apriso to examples of 5-aminosalicylates.
- October 9, 2012: No changes
- October 15, 2013: Added coverage criteria for the diagnosis of psoriatic arthritis.
- December 10, 2013: Added coverage criteria for the diagnosis of ankylosing spondylitis.
- October 7, 2014: Effective 1/1/2015, Cimzia (certolizumab pegol) will only be covered on the pharmacy benefit.
- September 16, 2015: No changes
- January 1, 2016: Administrative change to rebranded template.
- September 13, 2016: Effective 1/1/2017: Coverage requires trial and failure of treatment with, contraindication to or clinical inappropriateness of treatment with at least two of the following agents where indicated: Humira, Enbrel, Remicade, Simponi, Simponi Aria, and Stelara. Added exception language for Members new to the plan and stable on Cimzia prior to enrollment.
- April 11, 2017: Administrative update, Adding Tufts Health RITogether to the template.
- July 11, 2017: Administrative update to add the following Limitation: Samples, free goods or similar offerings of Cimzia (certolizumab) do not qualify for an established clinical response and will not be considered for prior authorization.

**BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION**

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They are used in conjunction with a Member’s benefit document and in coordination with the Member’s physician(s). The plan makes coverage decisions on a case-by-case basis considering the individual Member’s health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical
coverage criteria based on current literature review, consultation with practicing physicians in the
service area who are medical experts in the particular field, FDA and other government agency
policies, and standards adopted by national accreditation organizations. The plan revises and updates
Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes
available that suggests needed revisions.

This Pharmacy Medical Necessity Guideline does not apply to Uniformed Services Family Health Plan
Members or to certain delegated service arrangements. Unless otherwise noted in the Member’s
benefit document or applicable Pharmacy Medical Necessity Guideline, Pharmacy Medical Necessity
Guidelines do not apply to CareLink℠ Members. For self-insured plans, drug coverage may vary
depending on the terms of the benefit document. If a discrepancy exists between a coverage guideline
and a self-insured Member’s benefit document, the provisions of the benefit document will govern.
Applicable state or federal mandates will take precedence.
For Tufts Health Plan Medicare Preferred, please refer to Tufts Health Plan Medicare Preferred Prior
Authorization Criteria.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of
this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be
adjudicated. Claims payment is subject to Member eligibility and benefits on the date of service,
coordination of benefits, referral/authorization and utilization management guidelines when applicable,
and adherence to plan policies and procedures and claims editing logic.