### Part A: General Criteria Questions (must be completed and answer all that apply)

- Individual **has had** a tuberculin skin test (TST) or Centers for Disease Control (CDC) recommended equivalent to evaluate for latent tuberculosis prior to initiating etanercept.
- Individual **does not have** tuberculosis, invasive fungal infection, other active serious infection or a history of recurrent Infections
- Individual **will not receive in combination with** tofacitinib citrate (Xeljanz)
- Individual **will not receive in combination with** other Tumor Necrosis Factor (TNF) antagonists: (infliximab (Remicade®, Adalimumab (Humira®), etanercept (Enbrel®) or golimumab (Simponi™))
- Individual **will not receive in combination with** the following non-TNF immunomodulatory drugs: ((TNF) antagonists: abatacept (Orencia®), anakinra (Kineret®), or cyclophosphamides)
Part B: (Only complete the section for appropriate diagnosis and answer all that apply)

1. Crohn’s Disease (CD)
   - Individual is 18 years or older with moderately to severely active CD (Crohn’s disease)
   - Certolizumab pegol is being used to reduce signs or symptoms
   - Certolizumab pegol is being used to induce or maintain clinical response
   - Individual has failed to respond to, is intolerant of, or has a medical contraindication to conventional therapy:
     - 5-ASA (Pentasa®, Rowasa®, Asacal®, Lialda®, Canasa®, Apriso®), sulfasalazine (Azulfidine®), systemic corticosteroids (such as hydrocortisone, prednisone), or other immunosuppressants.
   - Please list therapies tried: ______________

2. Rheumatoid Arthritis (RA)
   - Individual is 18 years or older with moderately to severely active RA (rheumatoid arthritis)
   - Certolizumab pegol is being used to reduce signs or symptoms
   - Certolizumab pegol is being used to induce or maintain clinical response
   - Certolizumab pegol is being used to improve physical function
   - Individual has failed to respond to, is intolerant of, or has a medical contraindication to one of more nonbiologic disease-modifying antirheumatic drugs (DMARDs): methotrexate, sulfasalazine (Azulfidine®), hydroxychloroquine (Plaquenil®), leflunomide (Arava®) or other immunosuppressants
   - Please list nonbiologic DMARDS tried: ______________

3. Ankylosing Spondylitis (AS)
   - Individual is 18 years of age or older and with active AS (ankylosing spondylitis)
   - Certolizumab pegol is being used to reduce signs or symptoms of the disease
   - Individual failed to respond to, is intolerant of, or has medical contraindication to conventional therapy: nonsteroidal anti-inflammatory drugs (NSAIDS e.g. ibuprofen, Motrin®), or nonbiologic DMARDs such as methotrexate, sulfasalazine (Azulfidine®), hydroxychloroquine (Plaquenil®) or corticosteroids (e.g. hydrocortisone, prednisone) or other immunosuppressants
   - Please list therapy ies tried: ______________

4. Psoriatic Arthritis (PsA)
   - Individual 18 years of age or older and has active PsA (psoriatic arthritis)
   - Certolizumab pegol is being used to reduce signs or symptoms
   - Certolizumab pegol is being used to induce or maintain clinical response
   - Certolizumab pegol is being used to improve physical function
   - Individual failed to respond to, is intolerant of, or has medical contraindication to conventional therapies: nonbiologic DMARDs such as methotrexate, sulfasalazine (Azulfidine®), hydroxychloroquine (Plaquenil®), corticosteroids (such as hydrocortisone, prednisone) or other immunosuppressants
   - Please list treatment(s) tried: ______________

5. Other indications not specified above: (Please submit all supporting documents including labs, progress notes, imaging, etc., for review.)
   ______________
This request is being submitted:
☐ Pre-Claim
☐ Post-Claim. If checked, please attach the claim or indicate the claim number ________________

I attest the information provided is true and accurate to the best of my knowledge. I understand that the health plan or its designees may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

Name & Title of Provider or Provider Representative Completing Form / / Date
& attestation (Please Print)*

*The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted

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