# CIMplicity® Savings Program — Manual Reimbursement Form

**Please fax completed form to: 1-908-809-6248** **If you have questions, please call 1-844-277-6853**

**The CIMplicity Savings Program* helps cover eligible patients' out-of-pocket expenses associated with CIMZIA® (certolizumab pegol) Prefilled Syringe and Lyophilized Powder, as well as eligible patients' out-of-pocket costs associated with in-office administration of CIMZIA® (certolizumab pegol) Lyophilized Powder.**

## ELIGIBILITY

*For eligible, commercially insured patients only. View complete eligibility requirements and terms at cimzia.com/cimplicity-program. Program is available to individuals with commercial prescription insurance coverage for CIMZIA. Not valid for prescriptions that are reimbursed, in whole or in part, under Medicare (including Medicare Part D), Medicaid, similar federal- or state-funded programs (including any state prescription drug assistance programs and the Government Health Insurance Plan available in Puerto Rico), or where otherwise prohibited by law. Product dispensed pursuant to program rules and federal and state laws. Claims should not be submitted to any public payor (ie, Medicare, Medicaid, Medigap, Tricare, VA, or DoD) for reimbursement. The parties reserve the right to amend or end this program at any time without notice.

## CLAIM SUBMISSION PROCESS

NOTE: *For practices submitting claims for CIMZIA Lyophilized Powder administered via In-Office Injection (IOI) or for in-office administration-related costs for CIMZIA Lyophilized Powder, please be sure that the administering physician and the patient are enrolled in the CIMplicity Savings Program **before** submitting this claim form. Enrollment forms can be found in the Program Kit or you may enroll online at www.CIMZIASavingsProgram.com.*

Please submit the following:

- A completed reimbursement form within 180 days of the issue date on the patient's Explanation of Benefits (EOB)
- A copy of the EOB or dated pharmacy receipt (if the prescription was filled by a pharmacy and paid for by the patient)
- The assigned group number and member ID for the patient.

Submit claims via mail or fax:

**Mail:** CIMplicity Savings Program
P.O. Box 1089
Morristown, NJ 07962
**Fax:** 1-908-809-6248

Note: *Forms sent via fax will take up to 10 business days to process. Forms sent by mail may take up to 15 business days to process.*

**I am a:** ❑ **Patient/Guardian** *(form must be signed in order to receive reimbursement)* ❑ **Practice** *(patient signature not required for IOI submission)*

All fields marked with an asterisk (*) are required.

## PHYSICIAN AND PRACTICE

PHYSICIAN FIRST NAME* | PHYSICIAN LAST NAME* | PRACTICE NAME*

PRACTICE ADDRESS* *(FOR THE IOI PROGRAM, THIS SHOULD BE THE BILLING ADDRESS)* | PRACTICE ADDRESS 2

PRACTICE CITY* | PRACTICE STATE* | PRACTICE ZIP* | PRACTICE PHONE*

## PATIENT AND CLAIM

PATIENT FIRST NAME* | PATIENT LAST NAME* | PATIENT MIDDLE INITIAL

ADDRESS* | CITY* | STATE* | ZIP CODE*

DIAGNOSIS* | DATE OF BIRTH* | GENDER* ❑ MALE ❑ FEMALE ❑ OTHER ❑ NON-BINARY | NDC* ❑ 50474-0710-81 (prefilled syringe 6-pack) ❑ 50474-0700-62 (lyophilized powder vial) ❑ 50474-0710-79 (prefilled syringe 2-pack)

PATIENT GROUP NUMBER* | PATIENT MEMBER ID NUMBER* | DATE OF SERVICE* | PATIENT OUT-OF-POCKET AMOUNT FOR CIMZIA DRUG | PATIENT OUT-OF-POCKET AMOUNT FOR CIMZIA ADMINISTRATION

**SIGNATURE REQUIRED FOR PATIENT REIMBURSEMENT**

**Please mail reimbursement check to:** ❑ Patient's Address ❑ Practice's Address (c/o Patient Name)

"I certify that the information provided for this reimbursement request is accurate to the best of my knowledge, and the co-payment or out-of-pocket expenses requested for reimbursement were actually incurred. I also certify that the prescriptions are not reimbursed, in whole or part, under Medicare (including Medicare Part D), Medicaid, similar federal- or state-funded programs (including any state prescription drug assistance programs and the Government Health Insurance Plan available in Puerto Rico), or where otherwise prohibited by law."

PATIENT SIGNATURE: **OR** PATIENT PARENT OR GUARDIAN SIGNATURE:

**IMPORTANT SAFETY INFORMATION** **Serious and sometimes fatal side effects have been reported with CIMZIA, including tuberculosis (TB), bacterial sepsis, invasive fungal infections (such as histoplasmosis), and infections due to other opportunistic pathogens (such as Legionella or Listeria). Patients should be closely monitored for the signs and symptoms of infection during and after treatment with CIMZIA. Lymphoma and other malignancies, some fatal, have been reported in children and adolescent patients treated with TNF blockers, of which CIMZIA is a member.**

Other serious side effects have been reported with CIMZIA, including heart failure, anaphylaxis, or serious allergic reactions, hepatitis B reactivation, nervous system disorders, blood problems, and certain immune reactions (including a lupus-like syndrome). It is not recommended to administer CIMZIA with other biologic DMARDs due to an increased risk of infections. In pre-marketing controlled trials of all patient populations combined, the most common adverse reactions (≥8%) were upper respiratory infections (18%), rash (9%), and urinary tract infections (8%).

**See accompanying full Prescribing Information, including Boxed Warning, or visit www.CIMZIAhcp.com.**