

UnitedHealthcare Pharmacy  
Clinical Pharmacy Programs

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| Program Number    | 2025 P 1017-16   |
| Program           | Prior Authorization/Notification   |
| Medication        | Cimzia® (certolizumab)   |
| P&T Approval Date | 1/2007, 6/2008, 4/2009, 6/2009, 12/2009, 7/2010, 11/2010, 7/2011, 11/2011, 7/2012, 11/2012, 11/2013, 2/2015, 3/2016, 3/2017, 3/2018, 9/2018, 5/2019, 9/2019, 9/2020, 9/2021, 9/2022, 7/2023, 10/2024, 11/2024, 11/2025 |
| Effective Date    | 2/15/2026  |

**1. Background:**

Cimzia (certolizumab) is a tumor necrosis factor (TNF) blocker indicated for reducing signs and symptoms of Crohn's disease (CD) and maintaining clinical response in adult patients with moderately to severely active disease who have had an inadequate response to conventional therapy. Cimzia is also indicated for the treatment of adults with moderately to severely active rheumatoid arthritis (RA), treatment of adult patients with active psoriatic arthritis (PsA), treatment of adults with active ankylosing spondylitis (SpA), treatment of adults with moderate to severe plaque psoriasis (PS) who are candidates for systemic therapy or phototherapy, for the treatment of adults with non-radiographic axial spondyloarthritis (nr-axSpA), with objective signs of inflammation, and for the treatment of active polyarticular juvenile idiopathic arthritis (pJIA) in patients 2 years of age and older.

**2. Coverage Criteria<sup>a</sup>:**

**A. Crohn's Disease (CD)**

**1. Initial Authorization**

a. **Cimzia** will be approved based on **all** of the following criteria:

(1) Diagnosis of moderately to severely active Crohn's disease

**-AND-**

(2) Patient has had an inadequate response to conventional therapies (examples include anti-inflammatory drugs, corticosteroids, or oral immunosuppressive agents)

**-AND-**

(3) Patient is not receiving Cimzia in combination with another systemic targeted immunomodulator [e.g., adalimumab, Entyvio (vedolizumab), Omvoh (mirikizumab-mrkz), Rinvoq (upadacitinib), Skyrizi (risankizumab), Tremfya (guselkumab), ustekinumab] for treatment of the same indication.

**Authorization will be issued for 12 months.**

2. **Reauthorization**

a. **Cimzia** will be approved based on **both** of the following criteria:

(1) Documentation of positive clinical response to Cimzia therapy

**-AND-**

(2) Patient is not receiving Cimzia in combination with another systemic targeted immunomodulator [e.g., adalimumab, Entyvio (vedolizumab), Omvoh (mirikizumab-mrkz), Rinvoq (upadacitinib), Skyrizi (risankizumab), Tremfya (guselkumab), ustekinumab] for treatment of the same indication.

**Authorization will be issued for 12 months.**

**B. Rheumatoid Arthritis (RA)**

1. **Initial Authorization**

a. **Cimzia** will be approved based on **both** of the following criteria:

(1) Diagnosis of moderately to severely active rheumatoid arthritis

**-AND-**

(2) Patient is not receiving Cimzia in combination with another systemic targeted immunomodulator [e.g., adalimumab, Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)] for treatment of the same indication.

**Authorization will be issued for 12 months.**

2. **Reauthorization**

a. **Cimzia** will be approved based on **both** of the following criteria:

(1) Documentation of positive clinical response to Cimzia therapy

**-AND-**

(2) Patient is not receiving Cimzia in combination with another systemic targeted immunomodulator [e.g., adalimumab, Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)] for treatment of the same indication.

**Authorization will be issued for 12 months.**

**C. Psoriatic Arthritis (PsA)**

1. **Initial Authorization**

a. **Cimzia** will be approved based on **both** of the following criteria:

(1) Diagnosis of active psoriatic arthritis

**-AND-**

(2) Patient is not receiving Cimzia in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cosentyx (secukinumab), Enbrel (etanercept), Orenzia (abatacept), Otezla (apremilast), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Taltz (ixekizumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), ustekinumab] for treatment of the same indication.

**Authorization will be issued for 12 months.**

2. **Reauthorization**

a. **Cimzia** will be approved based on **both** of the following criteria:

(1) Documentation of positive clinical response to Cimzia therapy

**-AND-**

(2) Patient is not receiving Cimzia in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cosentyx (secukinumab), Enbrel (etanercept), Orenzia (abatacept), Otezla (apremilast), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Taltz (ixekizumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), ustekinumab] for treatment of the same indication.

**Authorization will be issued for 12 months.**

**D. Ankylosing Spondylitis (AS) and Non-radiographic Axial Spondyloarthritis (nr-axSpA)**

1. **Initial Authorization**

a. **Cimzia** will be approved based on **both** of the following criteria:

(1) Diagnosis of active ankylosing spondylitis or non-radiographic axial spondyloarthritis

**-AND-**

(2) Patient is not receiving Cimzia in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cosentyx (secukinumab), Enbrel (etanercept), Olumiant (baricitinib), Orenzia (abatacept), Simponi (golimumab), Rinvoq (upadacitinib), Taltz (ixekizumab), Xeljanz (tofacitinib)] for treatment of the same indication.

**Authorization will be issued for 12 months.**

2. **Reauthorization**

a. **Cimzia** will be approved based on **both** of the following criteria:

(1) Documentation of positive clinical response to Cimzia therapy

**-AND-**

(2) Patient is not receiving Cimzia in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), (secukinumab), Cosentyx (secukinumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Simponi (golimumab), Rinvoq (upadacitinib), Taltz (ixekizumab), Xeljanz (tofacitinib)] for treatment of the same indication.

**Authorization will be issued for 12 months.**

E. **Plaque Psoriasis (PS)**

1. **Initial Authorization**

a. **Cimzia** will be approved based on **both** of the following criteria:

(1) Diagnosis of moderate to severe plaque psoriasis

**-AND-**

(2) Patient is not receiving Cimzia in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), (secukinumab), Cosentyx (secukinumab), Enbrel (etanercept), Ilumya (tildrakizumab), Otezla (apremilast), Skyrizi (risankizumab), Siliq (brodalumab), Sotyktu (deucravacitinib), Taltz (ixekizumab), Tremfya (guselkumab), ustekinumab] for treatment of the same indication.

**Authorization will be issued for 12 months.**

2. **Reauthorization**

a. **Cimzia** will be approved based on **both** of the following criteria:

(1) Documentation of positive clinical response to Cimzia therapy

**-AND-**

(2) Patient is not receiving Cimzia in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cosentyx (secukinumab), Enbrel (etanercept), Ilumya (tildrakizumab), Otezla (apremilast),

Skyrizi (risankizumab), Siliq (brodalumab), Sotyktu (deucravacitinib), Taltz (ixekizumab), Tremfya (guselkumab), ustekinumab] for treatment of the same indication.

**Authorization will be issued for 12 months.**

**F. Polyarticular Juvenile Idiopathic Arthritis (pJIA)**

**1. Initial Authorization**

a. **Cimzia** will be approved based on **both** of the following criteria:

(1) Diagnosis active polyarticular juvenile idiopathic arthritis

**-AND-**

(2) Patient is not receiving Cimzia in combination with another systemic targeted immunomodulator [e.g., adalimumab, Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)] for treatment of the same indication.

**Authorization will be issued for 12 months.**

**2. Reauthorization**

a. **Cimzia** will be approved based on **both** of the following criteria:

(1) Documentation of positive clinical response to Cimzia therapy

**-AND-**

(2) Patient is not receiving Cimzia in combination with another systemic targeted immunomodulator [e.g., adalimumab, Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)] for treatment of the same indication.

**Authorization will be issued for 12 months.**

<sup>a</sup> State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

**3. Additional Clinical Rules:**

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

#### 4. References:

1. Cimzia [package insert]. Smyrna, GA: UCB, Inc; September 2025.

| Program               | Prior Authorization/Notification - Cimzia (certolizumab)  |
|-----------------------|---|
| <b>Change Control</b> |   |
| 11/2013               | Background updated. New criteria for psoriatic arthritis and ankylosing spondylitis. Concomitant therapy criterion condensed to list four biologic DMARDs and revised to include Xeljanz. Reauthorization criteria revised to standard verbiage and to include concomitant therapy criterion. Extended reauthorization duration to 24 months. |
| 9/2014                | Administrative change - Tried/Failed exemption for State of New Jersey removed.   |
| 2/2015                | Annual review with no change to coverage criteria. Minor reformatting. Updated background and references.   |
| 3/2016                | Annual review. Added Otezla (apremilast) to the combination criteria for Psoriatic Arthritis. Updated references.   |
| 3/2017                | Annual review with no change to coverage criteria. Updated references.  |
| 3/2018                | Annual review with no change to coverage criteria.  |
| 9/2018                | Added coverage for plaque psoriasis. Updated background and references.   |
| 5/2019                | Addition of non-radiographic axial spondyloarthritis diagnosis. Updated background and reference.   |
| 9/2019                | Annual review. Updated reference.   |
| 9/2020                | Annual review. Changed reauthorization durations to 12 months. Updated reference.   |
| 9/2021                | Annual review with no change to coverage criteria.  |
| 9/2022                | Annual review. Updated JAK inhibitor and biologic DMARD examples with no change to coverage criteria. Added state mandate footnote.   |
| 7/2023                | Updated not receiving in combination language to targeted immunomodulator and updated examples.   |
| 10/2024               | Annual review with no change to coverage criteria.  |
| 11/2024               | Added coverage criteria for pJIA. Updated background and reference.   |
| 11/2025               | Annual review. Updated examples with no change to clinical intent. Updated references.  |