

**certolizumab pegol (Cimzia vials)****Medical Benefit Drug Policy****Place of Service**

Infusion Center Administration

Office Administration

Outpatient Facility Infusion Administration

**Drug Details****USP Category:** IMMUNOLOGICAL AGENTS**Mechanism of Action:** Disease-modifying antirheumatic agent**HCPCS:**

J0717:Injection, certolizumab pegol, 1 mg (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)

**How Supplied:**

- 200 mg lyophilized powder for reconstitution, in a single-use glass vial, with 1 mL of sterile water for Injection. Per product labeling, Cimzia lyophilized powder for reconstitution should be administered by a healthcare professional.

**Condition(s) listed in policy** *(see coverage criteria for details)*

- Ankylosing Spondylitis (AS) or Non-Radiographic Axial Spondyloarthritis (nr-axSpA)
- Crohn's Disease
- Plaque Psoriasis
- Polyarticular Juvenile Idiopathic Arthritis
- Psoriatic Arthritis
- Rheumatoid Arthritis

Any condition not listed in this policy requires a review to confirm it is medically necessary. For conditions that have not been approved for intended use by the Food and Drug Administration (i.e., off-label use), the criteria outlined in the California Code of Regulations (CCR), Title 22, Section 51303 and 51313 must be met.

**Special Instructions and Pertinent Information**

Provider must submit documentation (such as office chart notes, lab results or other clinical information) to ensure the member has met all medical necessity requirements.

The member's specific benefit may impact drug coverage. Other utilization management processes, and/or legal restrictions may take precedence over the application of this clinical criteria.

**Coverage Criteria****The following condition(s) require Prior Authorization/Preservice.****Ankylosing Spondylitis (AS) or Non-Radiographic Axial Spondyloarthritis (nr-axSpA)**

**Meets medical necessity if all the following are met:**

Initial

1. ***Effective 2/1/2026 and after:*** Age is consistent with the FDA-approved indication
2. Prescribed by or in consultation with a rheumatologist
3. Meets ONE of the following:
  - a. Inadequate response with a trial of any two-prescription strength NSAIDs
  - b. Intolerable GI adverse events after a trial of a prescription strength NSAID in combination with a PPI
  - c. Unable to take NSAIDs due to history of GI bleed
4. For ankylosing spondylitis (AS): Inadequate response or intolerable side effect with preferred infliximab (e.g., Avsola, Inflectra or Renflexis), or contraindication to all infliximab products
5. Not being used with other targeted immunomodulators (e.g., anti-TNFs, interleukin inhibitors, JAK inhibitors)

Reauthorization

1. Patient is responding to therapy
2. ***Effective 2/1/2026 and after:*** Not being used in combination with other targeted immunomodulators (e.g., anti-TNFs, interleukin inhibitors, JAK inhibitors)

**Covered Doses:**

400 mg given subcutaneously at Weeks 0, 2 and 4, followed by 200 mg every other week or 400 mg every four weeks

**Coverage Period:**

one year

**ICD-10:**

M45.0-M45.9, M48.8X1-M48.8X9

**Crohn's Disease**

**Meets medical necessity if all the following are met:**

Initial

1. ***Effective 2/1/2026 and after:*** Age consistent with the FDA-approved indication
2. ***Effective 2/1/2026 and after:*** Prescribed by or in consultation with a gastroenterologist
3. Inadequate response or intolerable side effect with preferred infliximab (e.g., Avsola, Inflectra or Renflexis), or contraindication to all infliximab products
4. Not used with other targeted immunomodulators (e.g., anti-TNFs, interleukin inhibitors, JAK inhibitors)

Reauthorization

1. Patient is responding to therapy

2. **Effective 2/1/2026 and after:** Not being used in combination with other targeted immunomodulators (e.g., anti-TNFs, interleukin inhibitors, JAK inhibitors)

**Covered Doses:**

400 mg given subcutaneously at Weeks 0, 2 and 4, followed by 400 mg given every four weeks

**Coverage Period:**

one year

**ICD-10:**

K50.00-K50.119, K50.80-K50.819, K50.90-K50.919

**Plaque Psoriasis**

**Meets medical necessity if all the following are met:**

Initial

1. Age is consistent with FDA-approved indication
2. Prescribed by or in consultation with a dermatologist or rheumatologist
3. Meets ONE of the following:
  - a. Baseline PASI score is 10 or more prior to starting immunomodulator therapy
  - b. Baseline BSA (body surface area) affected is 3% or more prior to starting immunomodulator therapy
  - c. Sensitive area is involved (i.e., groin, face, etc.)
  - d. Disease is otherwise debilitating
4. Inadequate response, intolerable side effect, or contraindication to ONE of the following:
  - a. Methotrexate, cyclosporine (Neoral), acitretin (Soriatane)
  - b. PUVA or UVB treatment
5. Inadequate response or intolerable side effect with preferred infliximab (e.g., Avsola, Inflectra or Renflexis), or contraindication to all infliximab products
6. Not being used in combination with other targeted immunomodulators (e.g., anti-TNFs, interleukin inhibitors, JAK inhibitors)

Reauthorization

1. Not being used in combination with other targeted immunomodulator (e.g., anti-TNFs, interleukin inhibitors, JAK inhibitors)
2. Meets ONE of the following:
  - a. Improvement in PASI score from baseline
  - b. Improvement in BSA from baseline
  - c. Decrease in sensitive area disease severity
  - d. Decrease in debilitating disease severity

**Covered Doses:**

400 mg given subcutaneously every other week.

For some patients (with body weight less than or equal to 90 kg), a dose of 400 mg initially and at Weeks 2 and 4, followed by 200 mg every other week may be considered.

**Coverage Period:**

Initial: 24 weeks

Reauthorization: one year

**ICD-10:**

L40.0-L40.4

**Polyarticular Juvenile Idiopathic Arthritis**

**Meets medical necessity if all the following are met:**

Initial

1. ***Effective 2/1/2026 and after:*** Age is consistent with FDA-approved indication
2. Prescribed by or in consultation with a rheumatologist
3. Inadequate response, or intolerable side effect with one disease modifying anti-rheumatic drug (DMARD) or patient is unable to take methotrexate
4. Inadequate response or intolerable side effect with preferred infliximab (e.g., Avsola, Inflectra or Renflexis), or contraindication to all infliximab products
5. Not being used in combination with other targeted immunomodulators (e.g., anti-TNFs, interleukin inhibitors, JAK inhibitors)

Reauthorization

1. Patient is responding to therapy
2. ***Effective 2/1/2026 and after:*** Not being used in combination with other targeted immunomodulators (e.g., anti-TNFs, interleukin inhibitors, JAK inhibitors)

**Covered Doses:**

- 10 kg (22 lbs) to less than 20 kg (44 lbs): 100 mg initially and at Weeks 2 and 4, followed by 50 mg every other week
- 20 kg (44 lbs) to less than 40 kg (88 lbs): 200 mg initially and at Weeks 2 and 4, followed by 100 mg every other week
- Greater than or equal to 40 kg (88 lbs): 400 mg initially and at Weeks 2 and 4, followed by 200 mg every other week

**Coverage Period:**

one year

**ICD-10:**

M08.09

**Psoriatic Arthritis**

**Meets medical necessity if all the following are met:**

Initial

1. ***Effective 2/1/2026 and after:*** Age is consistent with FDA-approved indication
2. Prescribed by or in consultation with a rheumatologist
3. Inadequate response, intolerance, or contraindication to one or more disease modifying anti-rheumatic drugs (DMARDs) or has a medical reason why methotrexate, sulfasalazine, and leflunomide cannot be used
4. Inadequate response or intolerable side effect with preferred infliximab (e.g., Avsola, Inflectra or Renflexis), or contraindication to all infliximab products
5. Not being used in combination with other targeted immunomodulators (e.g., anti-TNFs, interleukin inhibitors, JAK inhibitors)

Reauthorization

1. Patient is responding to therapy
2. ***Effective 2/1/2026 and after:*** Not being used in combination with other targeted immunomodulators (e.g., anti-TNFs, interleukin inhibitors, JAK inhibitors)

**Covered Doses:**

400 mg given subcutaneously at Weeks 0, 2 and 4, followed by 200 mg every other week. For maintenance dosing, 400 mg every 4 weeks can be considered.

**Coverage Period:**

one year

**ICD-10:**

L40.50-L40.59

**Rheumatoid Arthritis**

**Meets medical necessity if all the following are met:**

Initial

1. ***Effective 2/1/2026 and after:*** Age is consistent with FDA-approved indication
2. Prescribed by or in consultation with a rheumatologist
3. Inadequate response, intolerable side effect, or contraindication to a DMARD (e.g., methotrexate, hydroxychloroquine, leflunomide, and sulfasalazine)
4. Inadequate response or intolerable side effect with preferred infliximab (e.g., Avsola, Inflectra or Renflexis), or contraindication to all infliximab products
5. Not used in combination with other targeted immunomodulators (e.g., anti-TNFs, interleukin inhibitors, JAK inhibitors)

Reauthorization

1. Patient is responding to therapy
2. ***Effective 2/1/2026 and after:*** Not being used in combination with other targeted immunomodulators (e.g., anti-TNFs, interleukin inhibitors, JAK inhibitors)

**Covered Doses:**

400 mg given subcutaneously at Weeks 0, 2 and 4, followed by 200 mg every other week. For maintenance dosing, 400 mg every 4 weeks can be considered.

**Coverage Period:**

one year

**ICD-10:**

(X=0-9) M05.XXX, M06.0XX, M06.2XX, M06.3XX, M06.8XX, M06.9

**References**

1. AHFS. Available by subscription at <http://www.lexi.com>  
Cimzia (certolizumab pegol) [Prescribing Information]. Smyrna, GA: UCB, Inc.; 9/2024.  
DrugDex. Available by subscription at  
<http://www.micromedexsolutions.com/home/dispatch>
2. Fraenkel, L., Bathon, J.M., England, B.R., et al. 2021 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Care Res*, 2021;73:924-939.
3. Lichtenstein GR, Loftus EV, Isaacs KL, et al. ACG Clinical Guideline: Management of Crohn's Disease in Adults. *Am J Gastroenterol* 2018;113: 481-517.
4. Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. *J Am Acad Dermatol* 2019;80: 1029-72.
5. Ringold S MD, MS, Angeles-Han S MD, MSc, Beukelman T MD, MSCE, et al. 2019 American College of Rheumatology/Arthritis Foundation Guideline for the Treatment of Juvenile Idiopathic Arthritis: Therapeutic Approaches for Non-Systemic Polyarthritis, Sacroilitis, and Enthesitis. *Arthritis Rheum* 2019 Jun;71(6):846-863.
6. Rubin DT, Ananthakrishnan AN, Siegel CA, et al. ACG Clinical Guideline: Ulcerative Colitis in Adults. *Am J Gastroenterol* 2019;114: 384-413.
7. Singh JA, Guyatt G, Ogdie A, et al. 2018 American College of Rheumatology/National Psoriasis Foundation Guideline for the Treatment of Psoriatic Arthritis. *Arthritis Rheum* 2019; 71:5-32.
8. Ward, MM, Deodhar A, Gensler, LS, et al. 2019 Update of the American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network Recommendations for the Treatment of Ankylosing Spondylitis and Nonradiographic Axial Spondyloarthritis. *Arthritis Rheumatol*, 2019;71(10):1599-1613.

**Review History**

Date of Last Annual Review: 4Q2025

Changes from previous policy version:

- Crohn's disease: Added age, specialist, and reauthorization requirement

- Rheumatoid arthritis: Clarified prerequisite requirement to include DMARDs for rheumatoid arthritis, added age and reauthorization requirement
- Ankylosing spondylitis, Polyarticular juvenile idiopathic arthritis, Psoriatic arthritis: Added age and reauthorization requirement

*Blue Shield of California Medication Policy to Determine Medical Necessity  
Reviewed by P&T Committee*