FUTURE SCRIPTS

Please complete ALL information below and fax your request to 1-888-671-5285

Cimzia® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Active ankylosing spondylitis
- ❑ Active psoriatic arthritis
- ❑ Moderate to severe plaque psoriasis
- ❑ Moderately to severely active rheumatoid arthritis
- ❑ Moderately to severely active Crohn's disease
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Select if Cimzia is prescribed by or in consultation with one of the following specialists:

- ❑ Dermatologist
- ❑ Gastroenterologist
- ❑ Rheumatologist

For active ankylosing spondylitis, also answer the following:

Has the patient had a trial and failure, contraindication, or intolerance to two non-steroidal anti-inflammatory drugs (NSAIDs)? ❑ **Yes** ❑ **No**

For moderately to severely active Crohn's disease, also answer the following:

Select if the patient has had a trial and failure, contraindication, or intolerance to the following conventional therapies:

- ❑ 6-mercaptopurine (Purinethol)
- ❑ Azathioprine (Imuran)
- ❑ Corticosteroids (e.g., prednisone, methylprednisolone)
- ❑ Methotrexate (Rheumatrex, Trexall)

For moderately to severely active rheumatoid arthritis, also answer the following:

Has the patient had a trial and failure, contraindication, or intolerance to one non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., Rheumatrex/Trexall (methotrexate), Arava (leflunomide), Azulfidine (sulfasalazine)]? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following question:

Is there documentation the patient has had a positive clinical response to Cimzia therapy? ❑ **Yes** ❑ **No**

Cimzia® Prior Authorization Request Form (Page 2 of 2)

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Quantity Limit Requests:

What is the quantity requested per TREATMENT? _____ (number of injections) per _____ days (treatment duration)

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.

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