

OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION REQUEST FORM*

Directions: *The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff and faxed to 757-552-7429 or 1-877-800-2839. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct.*

Drug Name: Cimzia™ (certolizumab)

- Cimzia™ is indicated for the treatment of moderately- to severely-active Crohn's disease in adult patients who have inadequate response to conventional therapy.
- Cimzia™ is also used for moderately- to severely- active Rheumatoid Arthritis (as monotherapy or in combination with DMARDs)
- Cases of tuberculosis have been observed in patents receiving Cimzia™. Patients should be evaluated for latent tuberculosis infection with a tuberculin skin test. Treatment of latent tuberculosis infection should be initiated prior to therapy with Cimzia™.
- Cimzia™ and other TNF blockers may affect defenses against malignancies.

Please complete below: (ALL appropriate lines must be checked to qualify)

____ Prescriber is a Gastroenterologist or Rheumatologist

____ Patient is at least 18 years old

____ Crohn's disease is moderate to severe, with inadequate response to **ALL** of the following therapies:

- Failure of budesonide or high dose (40-60mg prednisone) steroids **AND** Failure of Remicade

____ Rheumatoid Arthritis is moderate to severe, with inadequate response to **ALL** of the following therapies:

- Patient has tried and failed at least one previous DMARD therapy (including, but not limited to azathioprine, methotrexate, auranofin, etc...) **AND** Patient has tried and failed Enbrel (etanercept)

Please complete below:

Patient Name _____

Member Number _____

Physician Signature _____

Date _____

Physician Name _____ Phone Number _____

Fax Number _____

Pharmacy Name _____ Pharmacy Tel # _____