

Cimzia® Prior Authorization Request Form

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

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below:					
<input type="checkbox"/> Ankylosing spondylitis <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Psoriatic arthritis <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Clinical information:					
Select if Cimzia is prescribed by one of the following specialists: <input type="checkbox"/> Gastroenterologist <input type="checkbox"/> Rheumatologist					
Has the patient had a trial and failure of at least one disease modifying antirheumatic drug (DMARD) for at least three months (e.g., methotrexate, azathioprine, auranofin, hydroxychloroquine, sulfasalazine, leflunomide)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For Crohn's disease, also answer the following:					
Has the patient had a trial and failure of budesonide or high dose (40-60 mg prednisone) steroids? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Medication being provided by: (Please check applicable box below)					
<input type="checkbox"/> Physician's office <input type="checkbox"/> PropriumRx <input type="checkbox"/> Specialty Pharmacy (specify name): _____					
Use of samples to initiate therapy does not meet step edit/ preauthorization criteria. *Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*					
Prescriber Signature: _____			Date: _____		

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.
 For urgent or expedited requests please call 1-800-711-4555.
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.