

**CIMZIA
Prior Authorization Form**

<input type="checkbox"/> Standard Request (72 hours) <input type="checkbox"/> Expedited Request (24 hours)	If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received.
---	---

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Medication: Cimzia	Strength:	Directions:	Quantity Dispensed:	Day Supply:
<input type="checkbox"/> New medication <input type="checkbox"/> Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.		

Billing Information

<input type="checkbox"/> Billed by PHARMACY dispensed to the member or provider for administration.	<input type="checkbox"/> Billed under MEDICAL benefit by provider. J CODE: _____ ICD-10 Code: _____	Place of Administration: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital/Clinic <input type="checkbox"/> Patient Home
--	--	--

Clinical Information

Diagnosis	Is the member's disease currently active?
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Psoriatic Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Ankylosing Spondylitis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Dominant Axial <input type="checkbox"/> Dominant Peripheral

Disease Severity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	PPD (tuberculin) test: <input type="checkbox"/> Positive <input type="checkbox"/> Negative Date: _____	Is the member currently using another TNF-blocking or biologic agent in combination with Cimzia? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Medication:</i> _____
--	---	---

