

Drug Coverage Review Request

Cimzia®



35045



SUPPLY ALL PRESCRIBER AND PATIENT INFORMATION

PRESCRIBER

MD First Name _____
MD Last Name _____
Address _____
City _____
State _____
Zip Code _____
Phone _____
Fax _____
DEA number (optional) _____

PATIENT

Cardholder's ID# _____
Patient Last Name _____
Patient First Name _____
Date of Birth _____
Address _____
City _____
State _____
Zip Code _____
Phone _____

SECTION A

Please answer the following questions

1. For which indication is this drug being prescribed?
 - Moderate to severe Crohn's disease (CD)
 - Moderate to severe rheumatoid arthritis
 - Other
2. Yes No Will the patient be receiving MORE THAN ONE biologic agent (for example, Cimzia, Enbrel, Kineret, Humira, Remicade, Ocrencia or Rituxan) AT THE SAME TIME?
3. Yes No Not Warranted Where warranted, will the patient be evaluated and screened for the presence of latent TB infection prior to initiation of therapy with this drug?
4. Yes No Has the patient received at least 4 weeks of therapy with this drug?
5. Yes No Not Applicable If **Yes** to **previous** question, has drug therapy provided SIGNIFICANT IMPROVEMENT in the patient's condition?
6. Yes No Has the patient PREVIOUSLY RECEIVED either Humira or Remicade?
7. Yes No If **Yes** to **previous** question, has therapy with either Humira or Remicade FAILED to adequately treat the patient's condition?
8. Yes No Did the patient experience INTOLERANCE to either Humira or Remicade?

SECTION B Physician Signature

PHYSICIAN SIGNATURE

DATE

FAX COMPLETED FORM TO: 1 800 837-0959

PLEASE DO NOT FAX WITH A COVER SHEET

Location: Nevada (15) Case Id: 9999999



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