



CIMZIA® (certolizumab pegol) - Prior Authorization/Prescription/Patient Enrollment Form

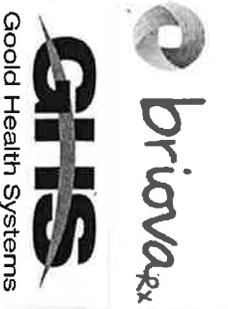
Complete form in its entirety and fax to number listed below

1 PATIENT INFORMATION

Last Name		First Name		Middle Initial
Date of Birth		Sex M <input type="checkbox"/> F <input type="checkbox"/>	Medicaid ID #	
Allergies: <input type="checkbox"/> NKA or _____				
Street Address		City		
State	County	Zip Code		
Home Phone		Cell Phone		
Parent/Guardian		Day Telephone	Night Telephone	
Emergency Contact		Relationship		Telephone

2 PRESCRIBER INFORMATION

Prescriber's Name		NPI Number	DEA Number	
Telephone Number	Fax Number	Hospital/Clinic Name		
Street Address		City		
State	County	Zip Code		
Contact Person at Office		Prescriber Specialty		



Fax Completed Form to:
Fax Number: 800-218-3221
Phone Number: 866-843-3604

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**Department of Vermont Health Access
 CIMZIA® (certolizumab pegol)
 PRIOR AUTHORIZATION REQUEST**

Patient Diagnosis: Rheumatoid Arthritis Psoriatic Arthritis Ankylosing Spondylitis Crohn's Disease

If requesting prescriber is not a Rheumatologist or Gastroenterologist, has one of these specialties been consulted on this case? Yes No

Specialist name: _____ Specialist Type: _____

List previous medications/therapies tried and failed for this condition: (include oral/injectable)

Therapy (and dates)	Reason for discontinuation
_____	_____
_____	_____
_____	_____

Prescriber Additional Comments: _____

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PRESCRIPTION

Dosage Form and Quantity:

Cimzia 200 mg/1 ml prefilled syringe (kit) Dispense Quantity: 1 (2 syringes)

or

Cimzia 200 mg lyophilized vial (kit) Dispense Quantity: 1 (2 vials)
 (for Health Care Professional administration)

or

Cimzia 200 mg/1 ml prefilled syringe (Starter kit-6) Dispense Quantity: 1 (6 syringes)
 400 mg (given as two subcutaneous injections of 200 mg) initially, and at Weeks 2 and 4

Sig: Dose/Route/Frequency:
 As above
 or
 400 mg (given as two subcutaneous injections of 200 mg) every four weeks
 (Crohn's, RA, PsA or AS)
 or
 200 mg (given as one subcutaneous injection) every two weeks (RA, PsA, AS)

Refill X: _____

Deliver product to: Patient's home MD office Clinic

Prescriber's Signature: _____ Date: _____