



# 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**

3 Department of Vermont Health Access CIMZIA® (certolizumab pegol) PRIOR AUTHORIZATION REQUEST	
Patient Diagnosis: <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Crohn's Disease	
If requesting prescriber is not a Rheumatologist or Gastroenterologist, has one of these specialties been consulted on this case? <input type="checkbox"/> Yes <input type="checkbox"/> 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:	
4 PRESCRIPTION	
<b>Dosage Form and Quantity:</b>	
<input type="checkbox"/> Cimzia 200 mg/1 ml prefilled syringe (kit)	Dispense Quantity: <u>1 (2 syringes)</u>
or	
<input type="checkbox"/> Cimzia 200 mg lyophilized vial (kit) (for Health Care Professional administration)	Dispense Quantity: <u>1 (2 vials)</u>
or	
<input type="checkbox"/> Cimzia 200 mg/1 ml prefilled syringe (Starter kit-6)	Dispense Quantity: <u>1 (6 syringes)</u>
400 mg (given as two subcutaneous injections of 200 mg) initially, and at Weeks 2 and 4	
Sig: Dose/Route/Frequency:	
<input type="checkbox"/> As above or	
<input type="checkbox"/> 400 mg (given as two subcutaneous injections of 200 mg) every four weeks (Crohn's or RA) or	
<input type="checkbox"/> 200 mg (given as one subcutaneous injection) every two weeks (RA)	
Refill X: _____	
Deliver product to: <input type="checkbox"/> Patient's home <input type="checkbox"/> MD office <input type="checkbox"/> Clinic	
Prescriber's Signature: _____ Date: _____	