



# 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:  
 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:

## 4 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:** \_\_\_\_\_