

Health New England
Medication Request Form (MRF)/Prescription Request
Cimzia® (certolizumab pegol)

Prior Authorization

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Cimzia®. Please complete this form and fax to ICORE Healthcare at (866) 364-2673. If you have any questions regarding this process, please contact ICORE Healthcare at (800) 775-5138.

Medication Request Information (please complete each section of this form prior to transmittal):

Patient Information		Physician Information	
Patient Name (required):		Physician Name (required):	
		Specialty (required):	
Patient Cell Phone #: () - 		NPI #:	
Patient HNE ID# (required):		HNE Provider #:	
Patient Date of Birth (required):		DEA # (required):	
Allergies:		Telephone #: () - 	
Diagnosis (required):		Fax # (required): () - 	
Drug Information			
Preferred Drug/Strength/Form: Cimzia® <input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> Powder for reconstitution			
Dose, Directions, and length of treatment (please be specific):		Quantity (per month):	Refills:
Physician Signature:		Date:	

Indication:

- Moderate to Severe Rheumatoid Arthritis.
- Crohn's Disease
- Other (please describe): _____

Documentation of Medical Necessity (*check all that apply*):

RA

- Patient has been seen by a Rheumatologist within the previous 12 months.
- Therapy being initiated or recommended by a gastroenterologist
- Rheumatoid Arthritis: Patient is intolerant to or failed therapy of at least one (1) DMARD or immunomodulator (including methotrexate, sulfasalazine, hydroxychloroquine, aurothioglucose, auranofin, gold sodium thiomalate, azathioprine, d-penicillamine, cyclosporine, leflunomide, or anakinra).
- Crohn's Disease: Patient is intolerant to or has the patient failed trial of at least one (1) of the following: a DMARD (i.e. azathioprine, 6-mercaptopurine, methotrexate, cyclosporine, corticosteroids) OR an aminosalicylate (i.e. mesalamine, olsalazine, sulfasalazine)?
- Patient failed or experienced intolerable side effects to Enbrel[®] and/or Humira[®]?
- Request is for continuation of therapy
- Active infections have been excluded (required). (including but not limited to chronic or localized infections, histoplasmosis, cytomegalovirus, tuberculosis, HIV)
- Pregnancy has been excluded or if female is of child-bearing age appropriate contraception is being utilized (use with caution)
- Will the patient be concurrently receiving Humira[®] (adalimumab), Kineret[®] (anakinra), Enbrel[®] (etanercept), Simponi[®] (golimumab), Remicade[®] (infliximab), Rituxan[®] (rituximab) or Oencia[®] (abatacept)
- Other pertinent history: _____