P.O. Box 30192
Salt Lake City, UT 84120-0192
801-442-4912 or 800-442-3219
Fax 801-442-3006

selecthealth℠

PREAUTHORIZATION FORM

Cimzia®
(certolizumab)

Therapeutic use: Reducing signs and symptoms of Crohn's disease and treatment of adults with moderately to severely active rheumatoid arthritis (RA)

Quantity Limit: 2 vials (200 mg each) per month after the titration phase (8 vials the first month)

Authorization Period: 12 months

Patient's name _____

Patient's ID# | | | | | | | | | | DOB | | | / | | / | | | | |

ICD-9 | | | | | | | | | | | | _____

Physician's name_____

Physician's Ph# (| | |) | | | - | | | | | Fax# | | | - | | | | |

Physician's signature_____ Date signed | | / | | / | | | | |

Supervising Physician's name_____ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" and respond to the following requests:			
1.	Has the adult patient been diagnosed with: • Moderate to severe active Rheumatoid Arthritis (meeting the ACR criteria)? • Moderate to severe active Crohn's disease?	 ❑ Yes ❑ Yes	 ❑ No ❑ No
2.	Is the prescribing physician a rheumatologist or gastroenterologist?	❑ Yes	❑ No
3.	Does the patient have persistent active disease and been treated for three months (less, if therapy discontinued due to complications) with one of the treatments listed below? a) Methotrexate >15 mg/week b) Leflunomide (Arava™) 100 mg daily on days 1-3, then 10-20 mg po qd c) Hydroxychloroquine 200 mg po bid for at least three months d) Sulfasalazine 1 g po bid-tid e) Injectable gold salts >25 mg im q2-4 weeks f) Oral gold 3 mg po qd-bid g) Azathioprine > 50 mg po qd h) D-penicillamine >250 mg po qd i) Cyclosporine > 2.5 mg/kg/day po	❑ Yes	❑ No
4.	Has the patient failed treatment with a TNF antagonist (Remicade, Enbrel or Humira)?	❑ Yes	❑ No
Cimzia will not be covered in combination with a TNF antagonist due to a lack of enhanced efficacy, and a higher risk of serious infection.			

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

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