

**CERTOLIZUMAB PEGOL (CIMZIA®)
PRIOR REVIEW/CERTIFICATION FAXBACK FORM**

INCOMPLETE FORMS MAY DELAY PROCESSING

ALL NC PROVIDERS MUST PROVIDE THEIR 5 DIGIT BCBSNC PROVIDER ID# BELOW

PRESCRIBER INFORMATION		PATIENT INFORMATION	
PRESCRIBER NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME	
CONTACT PERSON		BCBSNC ID	
PRESCRIBER PHONE	PRESCRIBER FAX	DATE OF BIRTH	
PRESCRIBER ADDRESS	CITY	STATE	ZIP

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Dx Code: _____

Please answer the following questions:

1. Has the patient been screened for the presence of latent TB infection? Yes No
2. Has the patient **previously used either etanercept (Enbrel®) or adalimumab (Humira®)** and such drug was ineffective in treating the patient's condition or was not tolerated? Yes No
3. Will the patient be receiving treatment with more than one biologic agent at the same time? (e.g., Enbrel®, Humira®, Kineret®, Simponi®, Remicade®, Orenicia® or Rituxan®)? Yes No

4. Please check the appropriate diagnosis and answer the related questions:

Moderate to Severe Crohn's Disease

- a. Has the patient had inadequate response to conventional therapy (i.e., 5-aminosalicylates, corticosteroids, 6-mercaptopurine, azathioprine, cyclosporine, methotrexate)? Yes No

Moderate to Severe Rheumatoid Arthritis

- a. Has the patient experienced a therapeutic failure / inadequate response with methotrexate (MTX) or has a contraindication? Yes No

OR

- b. Is the patient being treated for rapidly progressive and advancing disease? Yes No

Other Pertinent Information: _____

*****PLEASE NOTE: If you are prescribing more than 200 mg of Cimzia every other week please complete and sign page 2.**

Please certify the following by signing and dating below:

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required): _____ Date: _____

Fax completed form to BCBSNC at 1-800-795-9403



**BlueCross BlueShield
of North Carolina**

**COMPLETE PAGE 2 ONLY IF REQUESTING A QUANTITY LIMIT
EXCEPTION FOR CIMZIA**

PRESCRIBER INFORMATION		PATIENT INFORMATION
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH
PRACTICE ADDRESS	CITY	STATE ZIP

If you are requesting a quantity above the amount listed, check the appropriate box and provide the medical necessity of the increased dosage requested.

*Please note: This medication requires a **prior authorization** before a quantity limit override can be considered. Before submitting a request for a quantity level override, please ensure that a prior approval authorization has been submitted and/or approved (page 1). Otherwise, this request will deny.*

Dx Code: _____

Requested drug dose:

Greater than 200 mg of Cimzia every **other** week

Provide dosage requested and a description of medical necessity / rationale for this request:

Please certify the following by signing and dating below:

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required): _____ Date: _____

Fax completed form to BCBSNC at 1-800-795-9403