

# CIMZIA® PRIOR REVIEW FAXBACK FORM

PRESCRIBER INFORMATION		PATIENT INFORMATION
PHYSICIAN NAME	PROVIDER ID/TAX ID <i>(if out of state must have Tax ID)</i>	PATIENT NAME
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID
PHONE	FAX	PATIENT'S DATE OF BIRTH

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

1. Has the patient been screened for the presence of latent TB infection? .....  Yes  No

**Crohn's Disease**

2. Does the patient have moderately to severely active Crohn's disease? .....  Yes  No

3. Has the patient had inadequate response to conventional therapy? .....  Yes  No

List therapies tried: \_\_\_\_\_

**Rheumatoid Arthritis**

4. Does the patient have moderately to severely active rheumatoid arthritis? .....  Yes  No

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

**OR**

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

**Other Pertinent Information:** \_\_\_\_\_

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I certify that the above information is accurate and **is documented in the medical record.**

Prescriber's Signature Required: \_\_\_\_\_ Date \_\_\_\_\_

***Fax completed form to 1-800-795-9403***