Date of Request:____________________

Sterling Retiree Rx Prior Authorization Form

CIMZIA (Certolizumab Pegol)

Coverage Criteria / Required Medical Information
Patient must demonstrate inadequate response to at least 1 conventional therapy for Crohn's disease (i.e., prednisone, budesonide, sulfasalazine, azathioprine, mesalamine, infliximab or adalimumab).

Exclusion Criteria
Patient must be evaluated for latent TB with a PPD test and be treated if positive. Patients are excluded if they have an active infection or are on a concurrent biologic response modifier. Patient must also be assessed for the risk of hepatitis B and, if appropriate, be tested.

Member Information					
Name					
Enrollment/Card-holder ID Number					
Group/Plan		**Male**		**Female**	
Date of Birth		**Age**		**Weight in Kg**	
Street Address					
City		**State**		**Zip**	

Physicians Information					
Name					
Agent		**Contact Name**			
Specialty/Office					
Clinic Name					
Street Address					
City		**State**		**Zip**	
Phone		**Fax**			

Requested Drug		
CIMZIA	**Reason for Request**	
Condition/Diagnosis Related		

Clinical Drug/Lab History Pertinent to Request				
Labs: Baseline/Ongoing	**Strength/Dosage**			
Formulary Alternative(s) Attempted?	**Yes:**		**No:**	
Please List Alternative Formulary Drugs				
Comments				

Physicians Signature: ________________________________ **Fax Form to 1-877-847-9904**